

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11503

CERTIFICATE OF DEATH

11479

Reg. Dist. No. 21

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A-A</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>A-A</u>	
CITY OR TOWN <u>Brownwood</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Brownwood</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) <u>Brace</u> (First) <u>Thomas</u> (Middle) <u>Adams</u> (Last)				4. DATE OF DEATH <u>Dec. 15</u> 19 <u>53</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Feb 20 1907</u>	9. AGE last birthday <u>46</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Brownwood, A.A.</u>	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jacob A Adams</u>				14. MOTHER'S MAIDEN NAME <u>Lucile Hunt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Jacob Adams</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
916.0 IMMEDIATE CAUSE (A) <u>BURNS - Third degree</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Entire body</u>						<u> sudden</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) <u>HOME</u> (County) <u>AA CO</u> (State) <u>MD</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12 15 55 P</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None caught fire</u>			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19 <u>53</u> , that I last saw the deceased alive on....., 19....., and that death occurred at..... <u>P</u>M, from the causes and on the date stated above.							
SIGNATURE <u>E. H. Hunt</u>		M. D.		ADDRESS (Street, city, town, state) <u>Amesbury, Md</u>		DATE SIGNED <u>12/16/53</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>Dec 19/53</u>		NAME OF CEMETERY OR CREMATORY <u>St. Trinit</u>		LOCATION (City, town, or county) <u>St. Trinit</u>	
24. REC'D BY REGISTRAR <u>Dec. 19, 1955</u>		REGISTRAR'S SIGNATURE <u>J. D. Johnson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Amesbury</u>		ADDRESS	

CERTIFICATE OF DEATH

11303

1. NAME OF DECEASED

2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH

6. OCCUPATION
7. MARITAL STATUS
8. EDUCATION
9. RELIGION

10. CAUSE OF DEATH
11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN
13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES
15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED'S NEXT OF KIN
17. SIGNATURE OF DECEASED'S ATTORNEY

18. SIGNATURE OF DECEASED'S MINISTER OF RELIGION
19. SIGNATURE OF DECEASED'S CHURCH

20. SIGNATURE OF DECEASED'S FUNERAL HOME

BUREAU V. S.

DEC 21 1955

RECEIVED

11303

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

111719 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11480

Item 6 see Birth Cert.

12/19/55

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		<u>11 hrs.</u>		TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>U.S. Naval Hospital</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Baby Boy</u> <u>ALVARDO</u>				<u>December 19</u> <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>Puerto Rican</u>	<u>Single</u>	<u>12-19-55</u>	<u>11</u> yrs.	Months Days	Hours Min.	<u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>USA-Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Ramon Alvarado</u>				<u>Efigenia Diaz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>USNH Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>762.5</u> IMMEDIATE CAUSE (A) <u>Atelectasis (pulmonary) with immaturity</u>						<u>762.5</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>12-19-55</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-19</u>, 19 <u>55</u>, to <u>12-19</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>12-19</u>, 19 <u>55</u>, and that death occurred at <u>0955</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>E.R. Peters Lt USN</u>		<u>U.S. Naval Hospital</u> <u>Annapolis, Maryland</u>		<u>12-20-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12/21/55</u>		<u>NAVAL CEMETERY</u>		<u>ANNAPOLIS MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec. 21, 1955</u>		<u>[Signature]</u>		<u>John M. Lyons</u>		<u>Annapolis, Md.</u>	

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11481

11476

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>177 West Street</u>				STREET ADDRESS (If rural give location) <u>177 West Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JANE</u> (Middle) <u>H</u> (Last) <u>ARMIGER</u>				(Month) <u>DECEMBER</u> (Day) <u>1</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 17, 1897</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Woodward</u>				14. MOTHER'S MAIDEN NAME <u>Mary Tierney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr Howard E. Armiger- same as # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
181X IMMEDIATE CAUSE (A) <u>Cancer of Bladder</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>with Metastasis</u>						<u>6 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>9/25/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Biopsy confirmed above</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>9/17</u> , 19 <u>55</u> , to <u>12/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/1</u> , 19 <u>55</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Mannie K Lawans</u>		DATE THEREOF <u>12-2-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Annapolis National Cem.</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR DATE <u>12-2-55</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>ANNAPOLIS, MD.</u>	

	Control	Alone	Group	Overall
<i>N</i>	60	60	60	180
Mean age (SD)	79.2 (5.2)	79.2 (5.2)	79.2 (5.2)	79.2 (5.2)
Female (%)	60	60	60	60
Married (%)	60	60	60	60
Education level (%)				
<High school	60	60	60	60
High school	60	60	60	60
Bachelor's degree	60	60	60	60
Postgraduate	60	60	60	60
Income level (%)				
<\$10,000	60	60	60	60
\$10,000-\$20,000	60	60	60	60
>\$20,000	60	60	60	60
Health status (%)				
Good	60	60	60	60
Fair	60	60	60	60
Poor	60	60	60	60
Medication (%)				
No	60	60	60	60
Yes	60	60	60	60
Comorbidities (%)				
Hypertension	60	60	60	60
Diabetes	60	60	60	60
Asthma	60	60	60	60
Heart disease	60	60	60	60
Cancer	60	60	60	60
Kidney disease	60	60	60	60
Liver disease	60	60	60	60
Stroke	60	60	60	60
Dementia	60	60	60	60
Mental health	60	60	60	60
Anxiety	60	60	60	60
Depression	60	60	60	60
Social support (%)				
Low	60	60	60	60
Medium	60	60	60	60
High	60	60	60	60
Quality of life (%)				
Low	60	60	60	60
Medium	60	60	60	60
High	60	60	60	60



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BUREAU V. S.

DEC 5 1955

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11482

11477 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ANNAPOLIS</u>		<u>12d.</u>		TOWN <u>EDGEWATER</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ANNE ARUNDEL GEN'L HOSP</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>WALTER</u> (First) <u>B.</u> (Middle) <u>ARMSTRONG</u> (Last)				4. DATE OF DEATH (Month) <u>DEC</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>May 22 1893</u>		9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NAVY OFF.</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bellton Spa N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Adelbert Armstrong</u>				14. MOTHER'S MAIDEN NAME <u>Coffey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u> (If Yes, give war or dates of service) <u>WW II</u>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Edith M. Armstrong Edgewater Md</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>525X PULMONARY FIBROSIS</u>						<u>2 MOS.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>RADIATION (X-RAY) & LIPOID PNEUMONIA</u>						<u>2 MOS + 2 YRS.</u>	
STATING UNDERLYING CAUSE LAST (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>11/23</u> , 19 <u>55</u> , to <u>12/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/4</u> , 19 <u>55</u> , and that death occurred at <u>10:25</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>John L. Hedrowan</u>				ADDRESS (Street, city, town, state) <u>90 Cathedral St. Annapolis, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Fort Myer Va.</u>	
24. REC'D BY REGISTRAR <u>Dec. 5, 1955</u>		REGISTRAR'S SIGNATURE <u>J. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Galesville Md</u>	

CHOTDUNRECH

THIS IS A CERTIFICATE OF DEATH, ISSUED BY THE BUREAU OF VITAL STATISTICS, STATE OF MARYLAND, DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1955

1. NAME OF DECEASED

2. SEX

3. PLACE OF BIRTH

4. DATE OF BIRTH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. TIME OF DEATH

9. TIME OF BURIAL

10. NAME OF BURIAL PLACE

11. NAME OF FUNERAL HOME

12. NAME OF MINISTER

13. NAME OF CHURCH

14. NAME OF CEMETERY

15. NAME OF INTERVIEWER

16. NAME OF REGISTRAR

17. NAME OF CLERK

18. NAME OF ASSISTANT CLERK

19. NAME OF DEPUTY CLERK

20. NAME OF DEPUTY ASSISTANT CLERK

21. NAME OF DEPUTY DEPUTY CLERK

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BUREAU V. A.

DEC 6 1955

RECEIVED

11504 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>A. A.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3401-4</u>			
TOWN <u>Manhattan Beach, Severna Pk.</u>				STREET ADDRESS (If rural give location) <u>2134 Mt. Holly St.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED: (First) <u>ERNEST</u>		(Middle)		(Last) <u>BACHMAN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec. 25, 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Sept. 10, 1882</u>	9. AGE last birthday: <u>73</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Banker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Banking</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Marcus Bachman</u>				14. MOTHER'S MAIDEN NAME: <u>Mary (unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY NO. <u>217-14-1258 A</u>		17. INFORMANT & ADDRESS: <u>Mr. Ernest S. Bachman-3623 Lochearn Dr.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>331X</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>on</u> , 19 <u>55</u> , to <u>12/25, 1955</u> , that I last saw the deceased alive on <u>12/25, 1955</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>G. Fred Hawkins, Jr.</u>		M. D. <u>1011 N. Charles St.</u>		DATE SIGNED <u>12/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/27/55</u>		REGISTRAR'S SIGNATURE <u>W. C. Hedrick</u>		24. FUNERAL DIRECTOR <u>Wm. J. Pickner & Sons - Baltimore</u>		ADDRESS <u>170</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11484

11505 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>A.A. Co.</u>		OR TOWN <u>Odenton Md.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>89 RURAL</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location)		ADDRESS <u>1100 Annapolis Rd</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>89 Bay drive</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) <u>Louis BARATTINI Sr.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12-8-1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED-DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>1892-</u>	
9. AGE last birthday <u>63</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Merchant Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Rochester N.Y.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>August</u>				14. MOTHER'S MAIDEN NAME <u>unk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>450.0</u>				IMMEDIATE CAUSE (A) <u>uremia</u>			
2. ANTECEDENT CAUSE(S) DUE TO <u>gen. arteriosclerosis</u>				3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>diabetes mellitus</u>			
4. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				5. DATE OF OPERATION <u>Sept. 1955</u>			
6. MAJOR FINDINGS OF OPERATION <u>amp. rt. leg (arteriosclerotic gangrene)</u>				7. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
8. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		9. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		10. WHERE DID INJURY OCCUR? (City or town) (County) (State)		11. HOW DID INJURY OCCUR?	
12. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		13. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		14. HOW DID INJURY OCCUR?		15. I hereby certify that I attended the deceased from <u>10/17/55</u> , 19....., to <u>12/8/55</u> , 19....., that I last saw the deceased alive on <u>12/8/55</u> , 19....., and that death occurred at <u>5 P</u>M, from the causes and on the date stated above.	
SIGNATURE <u>S. B. Brown</u> M.D.				ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u> DATE SIGNED <u>12/10/55</u>			
16. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		17. DATE THEREOF <u>12-12-</u>		18. NAME OF CEMETERY OR CREMATORY <u>Greek Cemetery</u>		19. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
20. REC'D BY REGISTRAR <u>Mr. J. Funch</u>		21. REGISTRAR'S SIGNATURE		22. FUNERAL DIRECTOR'S SIGNATURE <u>LAMBROS Inc</u>		23. ADDRESS <u>440 E North</u>	
DATE <u>Dec. 13, 1955</u>							

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11485

11506 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Crownsville</u>		<u>4 yrs. 34 days</u>		TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS <u>1632 McKellery Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>George</u> (Middle) <u>Berry</u> (Last) <u></u>				(Month) <u>12</u> (Day) <u>6</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>	<u>Widowed</u>	<u>11/02/83</u>	<u>72</u> yrs.	Months <u>—</u> Days <u>—</u>	Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Waiter</u>		<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel Berry</u>				<u>Liza Berry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>331X</u> IMMEDIATE CAUSE (A) <u>Cerebrovascular Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>About 11 days</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Cerebral Arteriosclerosis</u>				<u>4 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis, Generalized Arteriosclerosis.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>—</u>		<u>hypostatic pneumonia</u>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<u>—</u>		<u>—</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>—</u>		<u>—</u>		<u>—</u>			
22. I hereby certify that I attended the deceased from <u>10/23</u>, 19<u>51</u>, to <u>12/6</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12/6</u>, 19<u>55</u>, and that death occurred at <u>12:25p.m.</u> from the causes and on the date stated above.							
SIGNATURE		<u>(L. Benedict, M. D.)</u>		DATE SIGNED		<u>12/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>—</u>		<u>12/9/55</u>		<u>Int. Calvary</u>		<u>Anne Arundel Co. Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		35. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 13 1955</u>		<u>L. M. Joyce</u>		<u>Robert Williams</u>		<u>1701 N Bond St</u>	

This is a true and correct copy of the original as submitted to the Bureau of Health-Baltimore, Maryland, on December 12, 1955, by the Baltimore Health Department, and is being furnished to you for your information and use.

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE 12

Page One

1. NAME OF DECEASED: [Name] [Address] [City] [State] [Zip]

2. SEX: [Male/Female] 3. AGE: [Age] 4. DATE OF BIRTH: [Date]

5. PLACE OF BIRTH: [Place] 6. OCCUPATION: [Occupation]

7. CAUSE OF DEATH: [Cause] 8. MANNER OF DEATH: [Manner]

9. TIME OF DEATH: [Time] 10. PLACE OF DEATH: [Place]

11. SIGNATURE OF PHYSICIAN: [Signature] 12. SIGNATURE OF REGISTRAR: [Signature]

13. SIGNATURE OF WITNESS: [Signature] 14. SIGNATURE OF DECEASED: [Signature]

15. SIGNATURE OF DECEASED: [Signature] 16. SIGNATURE OF DECEASED: [Signature]

17. SIGNATURE OF DECEASED: [Signature] 18. SIGNATURE OF DECEASED: [Signature]

19. SIGNATURE OF DECEASED: [Signature] 20. SIGNATURE OF DECEASED: [Signature]

21. SIGNATURE OF DECEASED: [Signature] 22. SIGNATURE OF DECEASED: [Signature]

23. SIGNATURE OF DECEASED: [Signature] 24. SIGNATURE OF DECEASED: [Signature]

25. SIGNATURE OF DECEASED: [Signature] 26. SIGNATURE OF DECEASED: [Signature]

27. SIGNATURE OF DECEASED: [Signature] 28. SIGNATURE OF DECEASED: [Signature]

29. SIGNATURE OF DECEASED: [Signature] 30. SIGNATURE OF DECEASED: [Signature]

31. SIGNATURE OF DECEASED: [Signature] 32. SIGNATURE OF DECEASED: [Signature]

33. SIGNATURE OF DECEASED: [Signature] 34. SIGNATURE OF DECEASED: [Signature]

35. SIGNATURE OF DECEASED: [Signature] 36. SIGNATURE OF DECEASED: [Signature]

37. SIGNATURE OF DECEASED: [Signature] 38. SIGNATURE OF DECEASED: [Signature]

39. SIGNATURE OF DECEASED: [Signature] 40. SIGNATURE OF DECEASED: [Signature]

BUREAU V. 8

DEC 12, 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11486

11507

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Ala.</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Ala</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Belvedere Beach</u>				TOWN <u>Belvedere Beach</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Margaret</u> (Middle) <u>Conklin</u> (Last) <u>Bishop</u>				(Month) <u>12</u> (Day) <u>17</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Sept 3-1885</u>	<u>70</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home (Nursing)</u>		<u>New York State</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Halalock</u>				<u>Mary Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Kenneth E. Bishop</u> (2)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
157X IMMEDIATE CAUSE (A) <u>CARCINOMA, pancreas with metastasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPTEMBER 19 55</u> , to <u>DECEMBER 19 55</u> , that I last saw the deceased alive on <u>Dec 16</u> , 19 <u>55</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Francis J. Cold</u>				M.D. <u>SEVERNA PAUL MD</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>12-20-55</u>		<u>Cedar Bluff</u>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
DATE <u>Dec 19, 1955</u>				<u>Edw Collins</u>		<u>John M. Taylor Sons Annapolis Md</u>	
						ADDRESS	

INSTRUCTIONS

1. This form is to be filled out by the physician or other person who has attended the deceased. It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland. It is to be used for the purpose of recording the facts of the death, and for the purpose of determining the cause of death. It is to be filled out in the case of all deaths, whether the death is natural, accidental, or suicidal. It is to be filled out in the case of all deaths, whether the death is natural, accidental, or suicidal. It is to be filled out in the case of all deaths, whether the death is natural, accidental, or suicidal.

1907 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11487

11478 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		STATE <i>Maryland</i> COUNTY <i>A. A. x</i>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <i>10 Annapolis</i>		LENGTH OF STAY (In this place)		CITY OR TOWN <i>Annapolis - Salesville Md.</i>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>63 A. G. General</i>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>Martha B Brown</i>				<i>12 15 1955</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W</i>	8. DATE OF BIRTH <i>3-13-1884</i>	9. AGE last birthday <i>71</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic Private Family</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Salesville, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Gross</i>				14. MOTHER'S MAIDEN NAME <i>Martha Gross</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>192-26-5502</i>		17. INFORMANT & ADDRESS <i>Rosa Sembly - Salesville, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>443X Cerebral Accident</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 wks</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertension Border - Vascular Disease</i>				<i>10 yrs</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Generalized Atherosclerosis</i>				<i>10 yrs</i>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11/19</i> , 19 <i>55</i> , to <i>12/15</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12/15</i> , 19 <i>55</i> , and that death occurred at <i>10:21</i> A.M., from the causes and on the date stated above.							
SIGNATURE <i>Theodore H. Johnson MD</i>				ADDRESS (Street, city, town, state) <i>57 Robert Street Annapolis, Md.</i>		DATE SIGNED <i>12/16/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-19-55</i>		NAME OF CEMETERY OR CREMATORY <i>Eden</i>		LOCATION (City, town, or county) (State) <i>Salesville, Md.</i>	
24. REC'D BY REGISTRAR <i>Dec. 16, 1955</i>		REGISTRAR'S SIGNATURE <i>Wm. J. French</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr.</i>		ADDRESS <i>108 Wash. St. Annapolis, Md.</i>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED

W. J. ...

2. PLACE OF DEATH

General Hospital

3. SEX

Male

4. AGE

65

5. DATE OF DEATH

12-15-1955

6. TIME OF DEATH

10:00 AM

7. CAUSE OF DEATH

Myocardial Infarction

8. PLACE OF BIRTH
 9. OCCUPATION
 10. MARITAL STATUS
 11. PREVIOUS ILLNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. OTHER NOTES

BUREAU V. 5

DEC 19 1955

RECEIVED

12/15/55

12/15/55

12/15/55

12/15/55

12/15/55

15-14-25

William ...

DISCONTINUED

11508

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

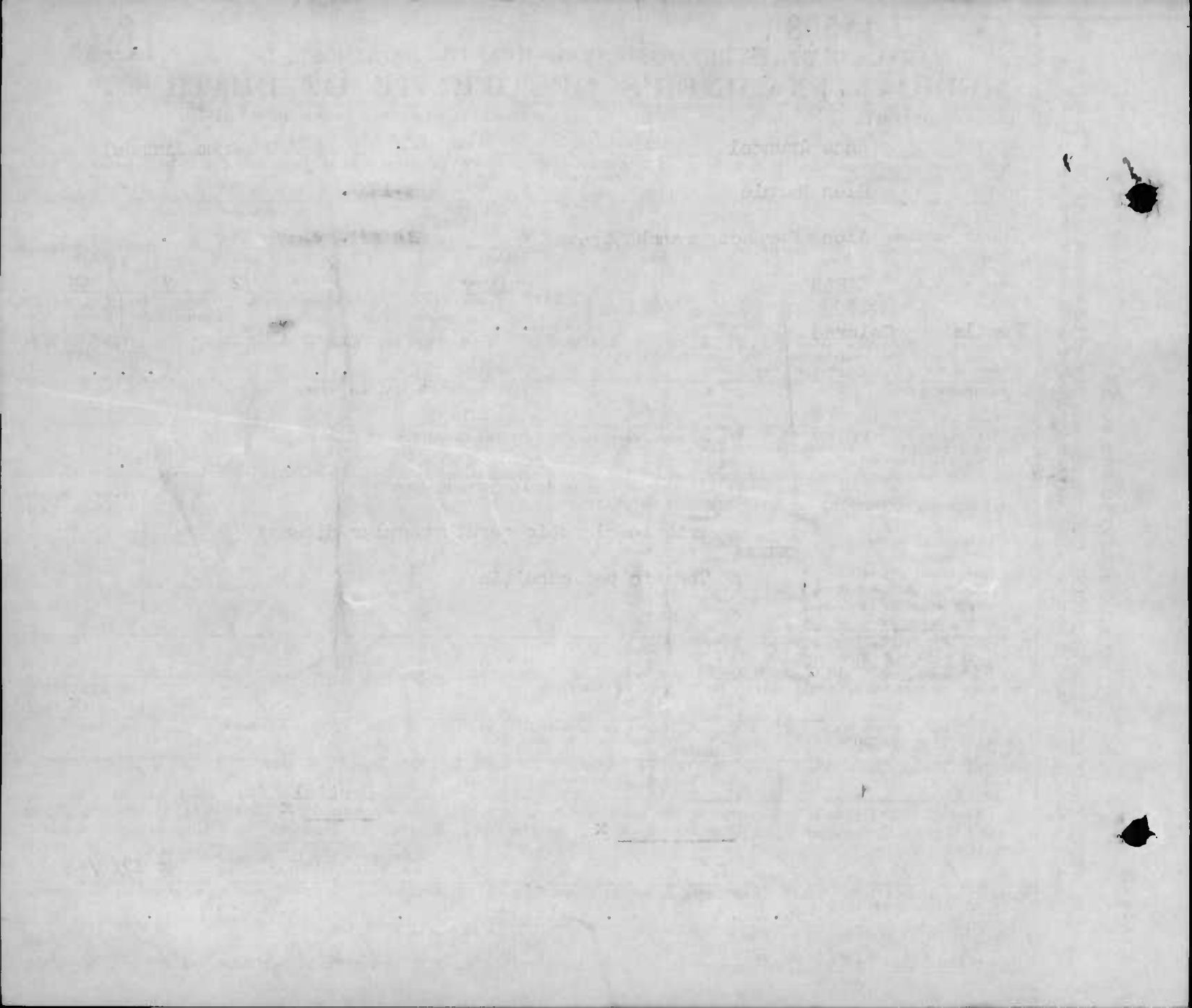
11488

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 23

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Anne Arundel	MARYLAND	STATE Md.	COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Glen Burnie	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Balto.	3601-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS Along Furnace Branch Stream		STREET ADDRESS (If rural, give location) 213 N. Schroeder St.	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) SARAH CHANEY		4. DATE OF DEATH (Month) (Day) (Year) 12 7 1955	
5. SEX: Female	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: Jan. 2. 1890
9. AGE last birthday: 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housewife		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Manning S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME: William Davis		14. MOTHER'S MAIDEN NAME: Binky ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 4 No (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: Ida Wilson 534 W. Preston St.	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a) Arteriosclerotic cardiovascular disease			
Antecedent cause(s) (b) Chronic pericarditis			
Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? Partial	
22. I hereby certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE William Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/8/55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF Dec. 12, 1955	NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	LOCATION (City, town, or county) (State) Ceder Hill Md.
DATE REC'D BY LOCAL REG. Dec 10 1955	REGISTRAR'S SIGNATURE R.W.	24. FUNERAL DIRECTOR Miss Kate R. Williams	ADDRESS 222 N. Schroeder St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11479

CERTIFICATE OF DEATH

11489

Reg. Dist. No. 21

Items 8,9 Film G190 1-3-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>a.a.co</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
10 TOWN <u>annapolis md</u>		2 MO		TOWN <u>Lothian</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Mary</u> (Middle) (Last) <u>Chase</u>				<u>Dec</u> <u>22</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>C</u>	<u>Married</u>	<u>Unknown</u>	<u>Approx. 65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>				<u>Harwood Md.</u>		<u>W.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Moses Johnson</u>				<u>Sophie Bess</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>9</u> — (If Yes, give war or dates of service)		—		<u>Agnes Booze, River, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332X IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 3</u> , 19 <u>55</u> , to <u>Dec 22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 21</u> , 19 <u>55</u> , and that death occurred at <u>6 a.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Emily H. Wilson</u> M.D.				ADDRESS (Street, city, town, state) <u>Lothian, Md</u>		DATE SIGNED <u>12-22-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/24/55</u>		<u>Chase</u>		<u>Lothian Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Dec 28, 1955</u>		<u>[Signature]</u>		<u>Bernard Hardisty Galbreath Ltd</u>			

11-9 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

REG. NO. 11

1. NAME OF DECEASED (Print Name)

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. MARITAL STATUS

10. CAUSE OF DEATH

11. MEDICAL HISTORY

12. MEDICAL CERTIFICATION

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF BURIAL SOCIETY

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF CHURCH

20. SIGNATURE OF OTHER

21. SIGNATURE OF

22. SIGNATURE OF

23. SIGNATURE OF

24. SIGNATURE OF

25. SIGNATURE OF

26. SIGNATURE OF

27. SIGNATURE OF

28. SIGNATURE OF

BUREAU V. 8

DEC 30 1955

RECEIVED

20100127201

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11490

11509

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MD</u> COUNTY <u>A.A.</u>		CITY OR TOWN <u>Arnold</u>		STREET ADDRESS <u>MAGO Vista RD.</u>	
CITY OR TOWN <u>Arnold</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Arnold</u>		STREET ADDRESS (if rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MAGO Vista RD.</u>				STREET ADDRESS <u>MAGO Vista RD.</u>			
3. NAME OF DECEASED (Type or Print) <u>James Crist</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>14</u> (Year) <u>1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>MAY 10, 1880</u>	
9. AGE last birthday <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>John Crist</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Adam Crist, Arnold MD.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>① Uremia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>② HYPertensive C.V. Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>③ Generalized Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 10, 1955</u> to <u>Dec. 14, 1955</u> that I last saw the deceased alive on <u>Dec. 14, 1955</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Severna Park Md 21156</u> DATE SIGNED <u>12/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 16, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>Dec. 16, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lilly & Zeiler Inc., 403 S. Wolfe St.</u> ADDRESS			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

INSTRUCTIONS

I

BUREAU V. S.

DEC 19 1955

RECEIVED

11510 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>A.A.</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Shedmore</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Shedmore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>Albert</i> (Middle) <i>Cromwell</i> (Last)		(Month) <i>Dec.</i> (Day) <i>1</i> (Year) <i>19 55</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widower</i>	8. DATE OF BIRTH <i>March 4, 1885</i>
9. AGE last birthday <i>70</i> yrs.		10. IF UNDER 1 YEAR (Months) <i>9</i> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Shedmore, A.A. Co</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Frank Cromwell</i>		14. MOTHER'S MAIDEN NAME <i>Rachel Colbert</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>214-05-2111</i>	
17. INFORMANT & ADDRESS <i>Francis Murray R2 Box 573</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
153X IMMEDIATE CAUSE (A) <i>Primary Carcinoma of the</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Large Intestine</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>none</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Dec 1, 1955</i> to <i>Dec 1, 1955</i> , that I last saw the deceased alive on <i>Dec 1, 1955</i> , and that death occurred at <i>9:45 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>R. L. Richardson</i>		DATE SIGNED <i>Dec 1, 1955</i>	
ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Dec 4/55</i>	
NAME OF CEMETERY OR CREMATORY <i>Broadneck</i>		LOCATION (City, town, or county) <i>St. Margarets</i>	
24. REC'D BY REGISTRAR <i>DEC 5 1955</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Johnson</i>	
REGISTRAR'S SIGNATURE <i>L. G. De Alba</i>		ADDRESS <i>Annapolis</i>	

The bottom copy may be retained by the hospital or attending physician. The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

File No. 10

1. NAME OF DECEASED (Print or Type)

2. PLACE OF DEATH

3. MARYLAND

4. COUNTY

5. CITY

6. STREET

7. ZIP CODE

8. DATE OF DEATH

9. TIME OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. AGENT OF DEATH

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESS

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF CLERK

20. SIGNATURE OF REGISTRAR

21. SIGNATURE OF NOTARY

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF DEPUTY SHERIFF

24. SIGNATURE OF CONSTABLE

25. SIGNATURE OF JAILER

26. SIGNATURE OF WARDEN

27. SIGNATURE OF CHIEF OF POLICE

28. SIGNATURE OF DETECTIVE

29. SIGNATURE OF INSPECTOR

30. SIGNATURE OF SUPERVISOR

31. SIGNATURE OF AGENT

32. SIGNATURE OF CLERK

33. SIGNATURE OF REGISTRAR

34. SIGNATURE OF NOTARY

35. SIGNATURE OF SHERIFF

36. SIGNATURE OF DEPUTY SHERIFF

37. SIGNATURE OF CONSTABLE

38. SIGNATURE OF JAILER

39. SIGNATURE OF WARDEN

40. SIGNATURE OF CHIEF OF POLICE

41. SIGNATURE OF DETECTIVE

42. SIGNATURE OF INSPECTOR

43. SIGNATURE OF SUPERVISOR

44. SIGNATURE OF AGENT

BUREAU V. 3

DEC 6 1955

RECEIVED

NOTED BY OFFICE OF THE ATTORNEY GENERAL

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11492

11430 **CERTIFICATE OF DEATH**Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A. Co</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>A. A. Co</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis - Shadyside, Md.</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. A. General Hosp.</u>				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) <u>Awilda G. Crowner</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>15</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>12-23-1902</u>	9. AGE last birthday <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>2</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sellman Scott</u>				14. MOTHER'S MAIDEN NAME <u>Lebbie Carter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Awilda Crowner Shadyside Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
451X IMMEDIATE CAUSE (A) <u>Shock</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Rupture of abdominal aeurism</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>12-15-55</u>		19b. MAJOR FINDINGS OF OPERATION <u></u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <u>12-15-55</u> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>12-15-55</u> to <u>12-15-55</u> , that I last saw the deceased alive on <u>12-15-55</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>A. T. Crowner</u> ADDRESS (Street, city, town, state) <u>M.D. 62 Ashland</u> DATE SIGNED <u>12-17-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-18-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Matthews</u>		LOCATION (City, town, or county) (State) <u>Shadyside Md.</u>	
24. REC'D BY REGISTRAR <u>Dec. 24, 1955</u>		REGISTRAR'S SIGNATURE <u>W. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>of Annapolis, Md.</u>	

EXHIBIT

THIS IS TO CERTIFY THAT THE FOLLOWING IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS SUBMITTED TO THE BUREAU OF VITAL STATISTICS, DISTRICT OF COLUMBIA, BY THE OFFICIALS OF THE DISTRICT OF COLUMBIA, AND THAT THE SAME HAS BEEN FILED IN THE OFFICE OF THE REGISTRAR OF VITAL STATISTICS, DISTRICT OF COLUMBIA, AND IS AVAILABLE FOR THE USE OF THE PUBLIC.

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH - WASHINGTON, D.C.

Form No. 100

1. PLACE OF BIRTH (State, Territory, Possession, or Foreign Country)

2. SEX

3. AGE

4. DATE OF BIRTH

5. TIME OF BIRTH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PERIOD OF ILLNESS

10. PREVIOUS ILLNESS

11. PREVIOUS SURGERY

12. PREVIOUS TRAUMA

13. PREVIOUS ACCIDENT

14. PREVIOUS POISONING

15. PREVIOUS INFECTION

16. PREVIOUS TUBERCULOSIS

17. PREVIOUS SYPHILIS

18. PREVIOUS GONORRHEA

19. PREVIOUS CHLAMYDIA

20. PREVIOUS TRICHOMONAS

21. PREVIOUS VENEREAL DISEASE

22. PREVIOUS SYPHILITIC LESIONS

23. PREVIOUS GONORRHEAL LESIONS

24. PREVIOUS CHLAMYDIAL LESIONS

25. PREVIOUS TRICHOMONAS LESIONS

26. PREVIOUS VENEREAL LESIONS

27. PREVIOUS SYPHILITIC LESIONS

28. PREVIOUS GONORRHEAL LESIONS

29. PREVIOUS CHLAMYDIAL LESIONS

30. PREVIOUS TRICHOMONAS LESIONS

31. PREVIOUS VENEREAL LESIONS

32. PREVIOUS SYPHILITIC LESIONS

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34. PREVIOUS CHLAMYDIAL LESIONS

35. PREVIOUS TRICHOMONAS LESIONS

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37. PREVIOUS SYPHILITIC LESIONS

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45. PREVIOUS TRICHOMONAS LESIONS

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94. PREVIOUS CHLAMYDIAL LESIONS

95. PREVIOUS TRICHOMONAS LESIONS

96. PREVIOUS VENEREAL LESIONS

97. PREVIOUS SYPHILITIC LESIONS

98. PREVIOUS GONORRHEAL LESIONS

99. PREVIOUS CHLAMYDIAL LESIONS

100. PREVIOUS TRICHOMONAS LESIONS

101. PREVIOUS VENEREAL LESIONS

102. PREVIOUS SYPHILITIC LESIONS

103. PREVIOUS GONORRHEAL LESIONS

104. PREVIOUS CHLAMYDIAL LESIONS

105. PREVIOUS TRICHOMONAS LESIONS

106. PREVIOUS VENEREAL LESIONS

107. PREVIOUS SYPHILITIC LESIONS

108. PREVIOUS GONORRHEAL LESIONS

109. PREVIOUS CHLAMYDIAL LESIONS

110. PREVIOUS TRICHOMONAS LESIONS

111. PREVIOUS VENEREAL LESIONS

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113. PREVIOUS GONORRHEAL LESIONS

114. PREVIOUS CHLAMYDIAL LESIONS

115. PREVIOUS TRICHOMONAS LESIONS

116. PREVIOUS VENEREAL LESIONS

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129. PREVIOUS CHLAMYDIAL LESIONS

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131. PREVIOUS VENEREAL LESIONS

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134. PREVIOUS CHLAMYDIAL LESIONS

135. PREVIOUS TRICHOMONAS LESIONS

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139. PREVIOUS CHLAMYDIAL LESIONS

140. PREVIOUS TRICHOMONAS LESIONS

141. PREVIOUS VENEREAL LESIONS

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145. PREVIOUS TRICHOMONAS LESIONS

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150. PREVIOUS TRICHOMONAS LESIONS

151. PREVIOUS VENEREAL LESIONS

152. PREVIOUS SYPHILITIC LESIONS

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159. PREVIOUS CHLAMYDIAL LESIONS

160. PREVIOUS TRICHOMONAS LESIONS

161. PREVIOUS VENEREAL LESIONS

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165. PREVIOUS TRICHOMONAS LESIONS

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199. PREVIOUS CHLAMYDIAL LESIONS

200. PREVIOUS TRICHOMONAS LESIONS

201. PREVIOUS VENEREAL LESIONS

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203. PREVIOUS GONORRHEAL LESIONS

204. PREVIOUS CHLAMYDIAL LESIONS

205. PREVIOUS TRICHOMONAS LESIONS

206. PREVIOUS VENEREAL LESIONS

207. PREVIOUS SYPHILITIC LESIONS

208. PREVIOUS GONORRHEAL LESIONS

209. PREVIOUS CHLAMYDIAL LESIONS

210. PREVIOUS TRICHOMONAS LESIONS

211. PREVIOUS VENEREAL LESIONS

212. PREVIOUS SYPHILITIC LESIONS

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216. PREVIOUS VENEREAL LESIONS

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230. PREVIOUS TRICHOMONAS LESIONS

231. PREVIOUS VENEREAL LESIONS

232. PREVIOUS SYPHILITIC LESIONS

233. PREVIOUS GONORRHEAL LESIONS

234. PREVIOUS CHLAMYDIAL LESIONS

235. PREVIOUS TRICHOMONAS LESIONS

236. PREVIOUS VENEREAL LESIONS

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11493

11511

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Middlebrook</i>		<i>18 mos.</i>		TOWN <i>Shrwood Forest</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Sam's Nursing Home</i>				STREET ADDRESS (If rural give location) <i>—</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>JOHN LODWICK DAVIES</i>				<i>DEC. 29 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>M</i>	<i>W</i>	<i>W</i>	<i>July 21, 1874</i>	<i>81</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mine superintendent</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>—</i>		<i>—</i>		<i>Penna.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Hopkin DAVIES</i>				<i>Hannah LODWICK</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>NO.</i>		16. SOCIAL SECURITY NO. <i>A 118-05-6882 B</i>		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				<i>Daughter, Mrs. Isabelle Caulfield (address same)</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
493X IMMEDIATE CAUSE (A) <i>Respiratory Failure</i>						<i>3 days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Pneumonia</i>						<i>3 days</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Tuberculosis of spine</i>						<i>10 yrs</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<i>—</i>		<i>—</i>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<i>—</i>		<i>—</i>		<i>—</i>		<i>—</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
<i>—</i>		<i>—</i>		<i>—</i>			
22. I hereby certify that I attended the deceased from <i>12/27</i>, 19<i>55</i>, to <i>12/29</i>, 19<i>55</i>, that I last saw the deceased alive on <i>12/27</i>, 19<i>55</i>, and that death occurred at <i>12:30 P.</i> M., from the causes and on the date stated above. <i>12/30/55</i>							
SIGNATURE				DATE SIGNED			
<i>John L. Hedzeman</i>				<i>90 Cathedral St., Annapolis, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>BURIAL</i>		<i>JAN. 3, 1956</i>		<i>ODD FELLOWS CEM.</i>		<i>SHAMOKIN, PA.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>JAN 2 1955</i>		<i>H. M. Jones</i>		<i>W. H. Lighton</i>		<i>New Burnside, Md.</i>	

RECEIVED

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INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11512 CERTIFICATE OF DEATH

11494 21
Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>aa</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>aa</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Riva</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>314 Washington St 10</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Riva View Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Annapolis Md</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EVA</u> (Middle) <u>CARLTON</u> (Last) <u>DAVIS</u>				(Month) <u>12</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec 3^d 1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Eastport Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Ferdinand Truscom</u>				14. MOTHER'S MAIDEN NAME <u>Annie E. Brewer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>J. Calvin Rogers</u> (2)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>gen. arteriosclerosis, c hypertension</u>				15 yrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1949</u> , to <u>Dec. 7, 1955</u> , that I last saw the deceased alive on <u>Dec. 7, 1955</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. Borrows</u> M.D.				ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u>		DATE SIGNED <u>12/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-12-55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 13, 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Saylor Sons</u>		ADDRESS <u>Annapolis Md</u>	

CERTIFICATE OF DEATH

Well, Dear Sir,

1. DECEASED'S NAME (Last, first, middle)

2. PLACE OF DEATH

3. SEX

4. AGE

5. RACE

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESS

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF MINISTER

18. SIGNATURE OF CHURCH OFFICIAL

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BUREAU-V. S.

JUL 13 1955

RECEIVED

11513

CERTIFICATE OF DEATH

11495

Reg. Dist. No. 24

Items 7, 14 Film G190 12-19-55 et

1. PLACE OF DEATH

COUNTY

Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

X TOWN Glen Burnie

LENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

90 PLAZA MANOR CONV. HOME

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Md.

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR
TOWN

Balto.

3401-4

STREET
ADDRESS

636 Bruce St

(If rural give location)

3. NAME OF
DECEASED
(Type or Print)

(First)

Georgeanna

(Middle)

(Last)

DORSEY

4. DATE (Month)

(Day)

(Year)

OF
DEATH

Dec 11

1955

5. SEX

F

6. COLOR OR
RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

Widow

8. DATE OF BIRTH

1870

9. AGE last birthday

85

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Minister

10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

Wm W. Achens

14. MOTHER'S MAIDEN NAME

Elizabeth Achens Bowen

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Janie Johnson, 636 Bruce St

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

420.0

IMMEDIATE CAUSE (A)

DUE TO

Arteriosclerotic heart disease

ANTECEDENT CAUSE(S)

DUE TO

Arteriosclerosis General

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

DUE TO

(C)

Multiple bed sores

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
or INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

While

Not while

at work ☐at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 9, 1955, to Dec 11, 1955, that I last saw the deceased alive on Dec 9, 1955, and that death occurred at 10:10 A.M. from the causes and on the date stated above.

SIGNATURE

L. J. DeAlto

M.D.

ADDRESS (Street, city, town, state)

Glen Burnie, Md.

DATE SIGNED

Dec 11, 1955

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

12/13/55

NAME OF CEMETERY OR CREMATORY

Mt. Zion

LOCATION (City, town, or county)

Balto.

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

L. J. DeAlto

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Wm A Jackson Fun. Home, Inc.
916 Penna. Ave.

DEC 13 1955

DATE

INSTRUCTIONS

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VS A15C 1-55 10M

1918 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. MEDICAL INVESTIGATION

11. NAME OF PHYSICIAN

12. NAME OF HOSPITAL

13. NAME OF NURSE

14. NAME OF BURIAL PLACE

15. NAME OF FUNERAL HOME

16. NAME OF CORONER

17. NAME OF JURY

18. NAME OF WITNESSES

19. NAME OF SIGNATURE

20. NAME OF OFFICIAL

BUREAU V. S.

DEC 14 1955

RECEIVED

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INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11496

11481 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>A. A. Co.</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>A. A. Co</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 Solomon Island Rd</u>		STREET ADDRESS (If rural give location) <u>63 Solomon Island Rd</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Charles Henry Douglas</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12 18 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>11-15-55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday yrs. <u>1</u> Months <u>3</u> Days <u>3</u> Hours <u>Min.</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Clarence Douglas</u>		14. MOTHER'S MAIDEN NAME <u>Emma Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Clarence Douglas-Annapolis</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
491X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)		<u>Bronchopneumonia</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... M., from the causes and on the date stated above.			
SIGNATURE <u>Chas. H. Hart</u>		DATE SIGNED <u>12/18/55</u>	
ADDRESS (Street, city, town, state) <u>Annapolis Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-20-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 24, 1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>	
REGISTRAR'S SIGNATURE <u>U. Trench</u>		ADDRESS <u>Annapolis, Md</u>	

20X5409354

BUREAU V. S.

DEC 29 1973

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11492

CERTIFICATE OF DEATH

11497

21

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location) <u>12 Shaw Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EDMUND</u>		(Middle) <u>HARRISON</u>		(Last) <u>ENGELKE</u>		(Month) <u>DECEMBER</u> (Day) <u>3</u> (Year) <u>19 55</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>December 24, 1901</u>		<u>53</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metallurgist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>War Dept. USGov.</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George L. Engelke</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Harrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
						<u>Mrs Jean Engelke- Wife- same as # 2</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
155X IMMEDIATE CAUSE (A) <u>gen. carcinomatosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>carcinoma of common duct</u>						<u>6 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>11/21/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>gen. carcinomatosis (Ca of common duct.)</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/10/55</u> , 19....., to <u>12/3/55</u> , 19....., that I last saw the deceased alive on <u>12/3/55</u> , 19....., and that death occurred at <u>11P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>S. B. Bormann</u>				ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-7-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec. 6, 1955</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>HOPPING FUNERAL HOME ANNAPOLIS, MD</u>	

11402 CERTIFICATE OF DEATH

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IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, at Baltimore, Maryland, this 12th day of December, 1953.

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BUREAU V. S.

DEC 8 1953

RECEIVED

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11498

MARYLAND STATE DEPARTMENT OF HEALTH

11483

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S.N. Hospital</u>		STREET ADDRESS (If rural, give location) <u>134 Prince Geo. St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ANTONIO</u> (Middle) <u>(N)</u> (Last) <u>FLORESTANO</u>	4. DATE OF DEATH	(Month) <u>12</u> (Day) <u>1</u> (Year) <u>1958</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>1-15-86</u>
9. AGE last birthday <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	11. BIRTHPLACE (State or foreign country)
<u>U.S. Navy</u>		<u>Italy</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>Guinepro Florestano</u>		14. MOTHER'S MAIDEN NAME <u>Lucia Sbars</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <u>Yes</u>		16. SOCIAL SECURITY No. <u>1908554939</u>	
17. INFORMANT AND ADDRESS <u>Josephine Florestano (2)</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>4343</u> Immediate cause (a) <u>Cardiac Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>accidental</u> causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <u>[Signature]</u> (Degree or title) ADDRESS <u>[Address]</u> DATE SIGNED <u>Dec 2/58</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>Dec 3-58</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 4, 1958</u>		REGISTER'S SIGNATURE <u>[Signature]</u>	
FUNERAL DIRECTOR <u>John M. Taylor, Son</u>		ADDRESS <u>Annapolis Md.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

DEC 6 1955

BUREAU V. 3

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11499

11484 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>A.A. Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS, MD.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS, MD.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>104 SEVERN AVE</u>				STREET ADDRESS <u>104 SEVERN AVE.</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CLARA</u> (Middle) <u>W.</u> (Last) <u>FOWLER</u>				(Month) <u>12</u> (Day) <u>1</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>1/13/1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN WOOLFORD</u>				14. MOTHER'S MAIDEN NAME <u>MARY PARRISH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY NO. <u>(If Yes, give war or dates of service)</u>		17. INFORMANT & ADDRESS <u>ROBERT J. WOOLFORD #2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>						<u>24 HOURS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC HEART DISEASE</u>						<u>10 YRS.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JULY</u> , 19 <u>55</u> , to <u>NOVEMBER</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>22 NOV</u> , 19 <u>55</u> , and that death occurred at <u>7:00 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edward A. Beck</u>				ADDRESS (Street, city, town, state) <u>41 South St. One Annapolis</u>		DATE SIGNED <u>7/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12/4/55</u>		NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
24. REC'D BY REGISTRAR <u>10 - U. Daniel</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR & SONS</u>		ADDRESS <u>ANNAPOLIS MD.</u>	
DATE <u>Dec. 5, 1955</u>							

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11500

1154

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>G.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pumphrey</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pumphrey</u>	
TOWN <u>12 Henson Ave</u>		TOWN <u>12 Henson Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Lloyd</u> (Middle) <u>Washington</u> (Last) <u>Galloway</u>		4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>11</u> (Year) <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11 Aug. 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labwork</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Gov.</u>	9. AGE last birthday <u>80</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Galloway</u>		14. MOTHER'S MAIDEN NAME <u>Olivera</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u> </u>	
17. INFORMANT AND ADDRESS <u>Suzie P. Galloway 12 Henson Ave</u>			

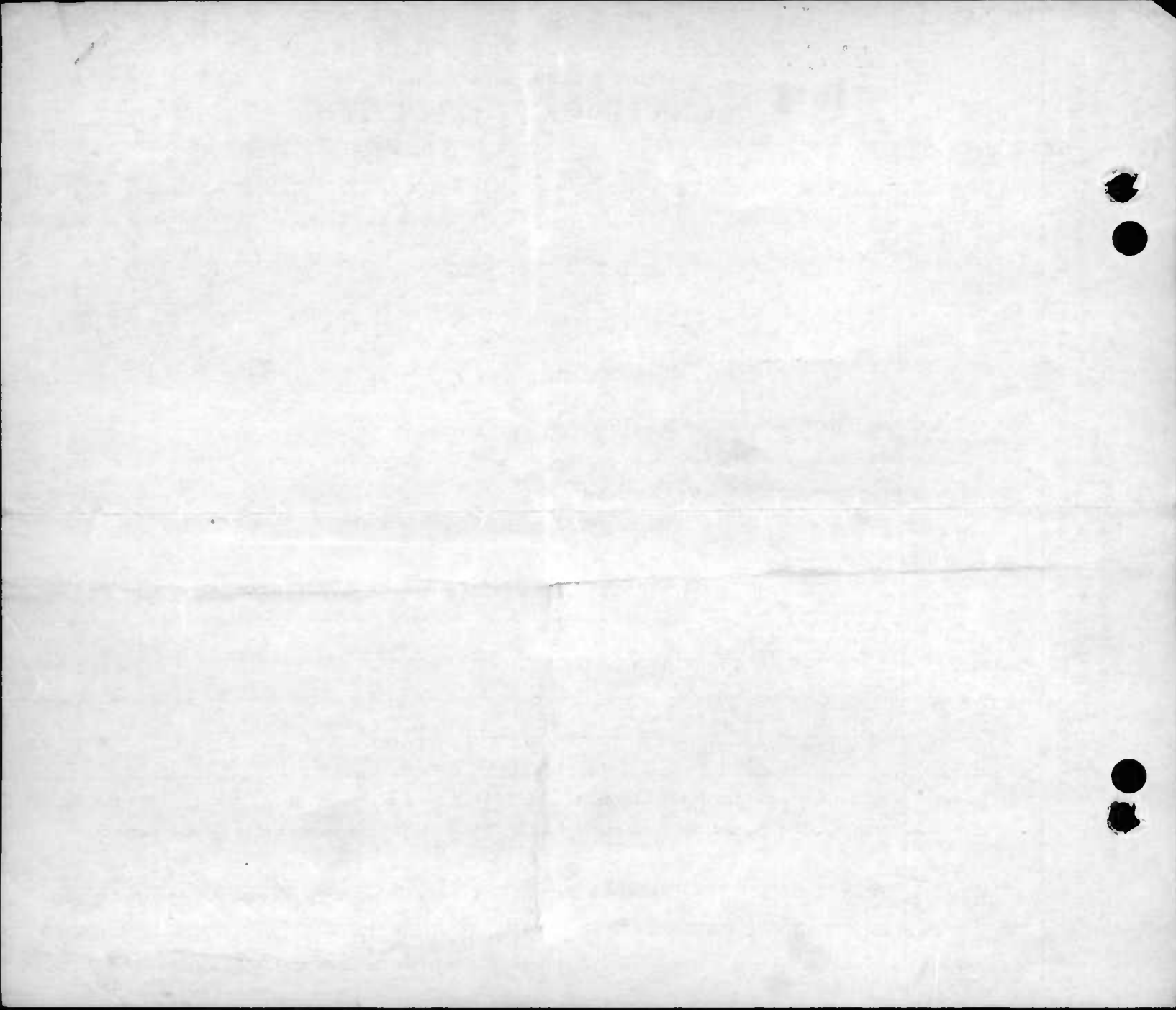
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Thrombosis</u>			<u>3 days</u>
Antecedent cause(s) (b) <u>Arterial Sclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u> </u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u> </u> PLACE (Home, farm, factory, street, OF office bldg., etc.) <u> </u> (CITY OR TOWN) <u> </u> (COUNTY) <u> </u> (STATE) <u> </u>		22. I hereby certify that I attended the deceased from <u>12 Oct</u> , 19 <u>55</u> , to <u>12 Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10 Dec</u> , 19 <u>55</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above.		DATE SIGNED <u>11 Dec 55</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u> </u> INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/> HOW DID INJURY OCCUR? <u> </u>		SIGNATURE <u>Ronald Blighston M.D.</u> ADDRESS <u>501 Cherry Hill Road Balto-2574</u>			

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> DATE <u>12-14-55</u> NAME OF CEMETERY OR CREMATORY <u>Brooklyn Rd</u> LOCATION (City, town, or county) <u>Brooklyn Rd</u> (State) <u> </u>		24. FUNERAL DIRECTOR <u>Chas. O. Wilson</u> ADDRESS <u> </u>	
DATE REC'D BY LOCAL REG. <u>12/15/55</u> REGISTRAR'S SIGNATURE <u>A. W. Keddick</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11501

11485

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>md.</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10. <i>Annapolis</i>				CITY OR TOWN <i>Annapolis</i>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100 <i>214 Center St</i>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Mary</i> (Middle) <i>Edith</i> (Last) <i>Galloway</i>				(Month) <i>Dec.</i> (Day) <i>13</i> (Year) <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>colored</i>	<i>widow</i>	<i>Sept. 10 1878</i>	<i>77</i> yrs.	<i>3</i> Months	<i>3</i> Days	<i>3</i> Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Domestic</i>		<i>Housewife</i>		<i>A. A. Co</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>John Hall</i>				<i>Eliza Hall</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>no</i>		<i>none</i>		<i>Rev. Wm. Galloway 208 N. Annapolis St. Baltimore</i>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <i>Arteriosclerotic Hypertensive</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Cardiovascular disease</i>				2 <i>yr.</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Grade III</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<i>0</i>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Dec 13, 1955</i> , to <i>Dec 13, 1955</i> , that I last saw the deceased alive on <i>Dec 13, 1955</i> , and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<i>R. L. Richardson</i>		<i>Dec 16, 1955</i>		<i>Brewer Hill</i>		<i>Annapolis Md</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Burial</i>		<i>J. B. Johnson</i>		<i>J. B. Johnson</i>		<i>Annapolis Md</i>	
DATE <i>Dec. 19, 1955</i>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A5C 1-55 10M

CERTIFICATE OF DEATH

Form 100-1-10

1. NAME OF DECEASED: JOHN B. DECEASED

2. SEX: MALE

3. AGE: 45

4. DATE OF DEATH: 12/15/1955

5. PLACE OF DEATH: HOME

6. CAUSE OF DEATH: HEART DISEASE

7. PLACE OF BIRTH: BALTIMORE, MD.

8. OCCUPATION: LABORER

9. MARITAL STATUS: SINGLE

10. MEDICAL HISTORY: NO PREVIOUS ILLNESS

*Center for Control & Prevention
Division of Field Epidemiology
Baltimore, Md.*

BUREAU V. S.

DEC 21 1955

RECEIVED

*Dec 17 1955
Div. of Field Epidemiology
Center for Control & Prevention*

*Dec 17 1955
Div. of Field Epidemiology
Center for Control & Prevention*

152-100-100-2

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11502

11486

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		<u>5 days</u>		TOWN <u>Odenton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General</u>				STREET ADDRESS (If rural give location) <u>Waugh Chapel Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MARY M GEORGE</u>				<u>DECEMBER 23 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>August 7, 1885</u>	<u>70 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House wife</u>		<u>own home</u>		<u>Baltimore County, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Fred OFF</u>				<u>Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mr. Wm. E. George- Son- Landover Hills,</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.1 IMMEDIATE CAUSE (A) <u>Massive Interseptal Infarct c</u></u>							
<u>ANTECEDENT CAUSE(S) DUE TO <u>Coronary Occlusion</u></u>						<u>1-5 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Unk.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>2</u>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/19</u>, 19<u>55</u>, to <u>12/23</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12/23</u>, 19<u>55</u>, and that death occurred at <u>1:50</u> P.M. from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Mannie Klawns</u>		<u>Dec. 27, 1955</u>		<u>Waugh Chapel</u>		<u>Odenton, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Burial</u>		<u>Dec. 27, 1955</u>		<u>HOPPING FUNERAL HOME</u>		<u>ANNAPOLIS, MD.</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11503

11515

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		STATE <i>Md.</i> COUNTY <i>C.A.</i>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <i>R.F.D. 4 Box 3</i>		LENGTH OF STAY (in this place)		CITY OR TOWN <i>Annapolis</i>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Annapolis, Md.</i>				STREET ADDRESS <i>R.F.D. 4 - Box 3</i>			
3. NAME OF DECEASED (Type or Print) <i>William E Hawkins</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>12-26-1955</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>Col</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>		8. DATE OF BIRTH <i>12-17-1903</i>	
9. AGE last birthday <i>52</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>		13. FATHER'S NAME <i>Richard J. Hawkins</i>		14. MOTHER'S MAIDEN NAME <i>Lola Little</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>1-10-100000</i>		17. INFORMANT & ADDRESS <i>Bertha Hawkins - Annapolis</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
431X IMMEDIATE CAUSE (A) <i>Acute Myocardial</i>						INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>6:30 PM</i>			
22. I hereby certify that I attended the deceased from <i>12/26/55</i> to <i>12/26/55</i>, that I last saw the deceased alive on <i>12/26/55</i>, and that death occurred at <i>11:00</i> M, from the causes and on the date stated above.							
SIGNATURE <i>R.L. Richardson</i>		DATE THEREOF <i>12-29-55</i>		NAME OF CEMETERY OR CREMATORY <i>Broad Neck</i>		LOCATION (City, town, or county) (State) <i>Skidmore Md.</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24. REC'D BY REGISTRAR <i>Mr. J. French</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr.</i>		ADDRESS <i>1082 Wash. St. - Annapolis Md.</i>	
DATE <i>28 1955</i>							

Richard Smith

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Dr. J. B. C. Smith

1891

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BUREAU V. S.

DEC 29 1955

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[Handwritten signature]

11516

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY <u>A.A.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>BAR HARBOR</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>BAR HARBOR</u>			
TOWN <u>BAR HARBOR</u>				TOWN <u>BAR HARBOR</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BAR HARBOR ROAD</u>				STREET ADDRESS (If rural give location) <u>BAR HARBOR ROAD</u>			
3. NAME OF DECEASED: <u>Jennie</u> (Middle) <u>Herbert</u>				4. DATE OF DEATH: <u>DEC. 20</u> 19 <u>55</u>			
(Type or Print) <u>HERBERT LOUISE JENNIE</u>							
5. SEX: <u>FEMALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>SEPT. 4, 1902</u>	
				9. AGE last birthday: <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>HOME</u>		11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>JEROME CHAMBERS VAN EVERA</u>				14. MOTHER'S MAIDEN NAME: <u>ARA FRANCES HATFIELD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY No.: <u>216-01-6400</u>		17. INFORMANT & ADDRESS: <u>MRS. L.G. WALKER, BAR HARBOR MD</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>CEREBRAL HEMORRHAGE</u>		<u>2 WEEKS</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIO VASCULAR DISEASE</u>		<u>10 YEARS</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JULY, 1956, to DEC. 20, 1955, that I last saw the deceased alive on DEC. 19, 1955, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

SIGNATURE <u>J. Brady Smith</u> (Degree or title)		DATE SIGNED <u>12/20/55</u>	
23. BURIAL, CREMATION, REMAINS (Specify) <u>12/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>RIVIERA BEACH, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 23, 1955</u>		REGISTRAR'S SIGNATURE <u>Ida M. Whitman</u>	
24. FUNERAL DIRECTOR <u>McLurey Funeral Home</u>		ADDRESS	

Sent State Dept Dec 23/55

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 28 1953

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 5,6, FilmG191 1-11-56 et

11487

CERTIFICATE OF DEATH

11505

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>a a</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>a a</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>10 Annapolis</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Pine wiff Beach</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>13 a. a. General</i>				STREET ADDRESS (If rural give location) <i>Edgewater md</i>			
3. NAME OF DECEASED (Type or Print) <i>Virginia K. Hess</i>				4. DATE OF DEATH (Month) <i>Dec</i> (Day) <i>29</i> (Year) <i>1955</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>Dec 28-55</i>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Annapolis</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Wale Hess</i>				14. MOTHER'S MAIDEN NAME <i>Eleanor Beard</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Wale Hess 12 above</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
762.5 IMMEDIATE CAUSE (A) <i>PULMONARY HYALINE MEMBRANE DISEASE</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 DAY</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>PREMATURITY</i>						<i>1 DAY</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>29</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>28 Dec, 1955</i> to <i>29 Dec, 1955</i> that I last saw the deceased alive on <i>29 Dec, 1955</i> and that death occurred at <i>12:45 PM</i> from the causes and on the date stated above. SIGNATURE <i>Thos K Walker MD</i> ADDRESS <i>Carol Hall Annapolis</i> DATE SIGNED <i>30 Dec 55</i> M.D. <i>Carol Hall</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Dec 31/55</i>		NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cemetery</i>		LOCATION (City, town, or county) <i>Annapolis md</i>	
24. REC'D BY REGISTRAR DATE <i>Dec. 31, 1955</i>		REGISTRAR'S SIGNATURE <i>J. J. Daniel</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Ben E. Haggerty</i>		ADDRESS <i>Annapolis md</i>	

20V5280312

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (PRINT OR TYPE)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF CHURCH

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF BURIAL PLACE

19. SIGNATURE OF INTERMENT

20. SIGNATURE OF RECORDS

21. SIGNATURE OF VITALS

22. SIGNATURE OF DEATH

23. SIGNATURE OF BIRTH

24. SIGNATURE OF MARRIAGE

25. SIGNATURE OF DIVORCE

26. SIGNATURE OF ADULTERY

27. SIGNATURE OF FORNICATION

28. SIGNATURE OF SODOMY

29. SIGNATURE OF OBSCENITY

30. SIGNATURE OF CRUELTY

31. SIGNATURE OF INDECENCY

32. SIGNATURE OF DECEIT

33. SIGNATURE OF FRAUD

34. SIGNATURE OF LARCENY

35. SIGNATURE OF BURGLARY

36. SIGNATURE OF ROBBERY

37. SIGNATURE OF KIDNAPING

38. SIGNATURE OF HOSTAGE

39. SIGNATURE OF CONSPIRACY

40. SIGNATURE OF RICO

41. SIGNATURE OF OBSTRUCTION OF JUSTICE

42. SIGNATURE OF PERJURY

43. SIGNATURE OF FALSE EVIDENCE

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7, Film G 190, 12/12/55 bh

11506

11517

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>		CITY <u>Balt. City</u> COUNTY <u>Ind.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>GLENBURNIE</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>3001-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MAJOR CONV. HOME</u>				STREET ADDRESS (If rural give location) <u>1732 D. Bond St Balt. 13 ml.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JUNIUS</u>		(Middle)		(Last) <u>HILL</u>		(Month) (Day) (Year) <u>Dec. 2 1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10/9/85</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SA</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Robert H Hill</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
491X IMMEDIATE CAUSE (A) <u>BRONCHOPNEUMONIA</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>ARTERIOSCLEROSIS GENERAL</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 1955</u> to <u>Dec 2, 1955</u> that I last saw the deceased alive on <u>Nov 29, 1955</u> and that death occurred at <u>5:45 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John A. Lee</u>		M.D. <u>Glen Burnie</u>		ADDRESS (Street, city, town, state) <u>Dec 2, 1955</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>12/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Witchamary Cemetery A.A. Co Ind.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>DEC 7 1955</u>		REGISTRAR'S SIGNATURE <u>L. J. Delaney</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Williams</u>		ADDRESS <u>1701 D Bond St</u>	

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BUREAU V. S.

REC 7 1955

RECEIVED

11518 CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Shady Side</u>				TOWN <u>Shady Side</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Aida</u> (Middle) <u>Hogue</u> (Last)				(Month) <u>December</u> (Day) <u>24</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Fem</u>	<u>White</u>	<u>Married</u>	<u>Dec 5, 1898</u>	<u>57</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Practitioner</u>		<u>Catholic, Laqueir, Va.</u>		<u>Shady Side, Md.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Henderson</u>				<u>Shady Side, Md.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Walter Hogue, Shady Side, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Apparent Coronary Occlusion</u> with Myocardial Infarction							
ANTECEDENT CAUSE(S) DUE TO <u>Not known</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19, and that death occurred at 9:30 PM, from the causes and on the date stated above.							
SIGNATURE <u>J. B. Dent</u>				DATE SIGNED <u>Dec. 26, 1955</u>			
M.D. <u>Shady Side, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/27/53</u>		<u>Fort Lincoln</u>		<u>Wash. D. C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>J. B. Dent</u>		<u>Hardesty Funeral Home</u>		<u>Anne Arundel Co., Md.</u>	
DATE <u>Dec. 31-55</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

CERTIFICATE OF DEATH

DATE OF DEATH

DEATH RECORDS DIVISION OF HEALTH

PLACE OF DEATH

NAME OF DECEASED

AGE

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DATE OF BIRTH

CAUSE OF DEATH

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Dec 21 1898

Robertson (Robert Ferguson, son)

Shelby

John Henderson

Walter Hagen, Shelby Co, Md

BUREAU V. S.

JAN 2 1899

RECEIVED

Received 12/21/98 Fort Lincoln Wash. D. C.
Henderson, Robert, son of Robert Ferguson, son of John Henderson, Shelby Co, Md

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11508

11519

CERTIFICATE OF DEATH

Items 5,6,7, Film G191 1-6-56 et

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>a a</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>a a</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Bristol</i>		<i>85 yrs.</i>		TOWN <i>Bristol</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Lizzie Foggett Hopkins</i>				<i>Dec 23 19 55</i>			
5. SEX	6. COLOR OF RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>White</i>	<i>Widow</i>	<i>Aug 14 1870</i>	<i>85</i>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>				<i>Bristol Md.</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Hendrix Charles Mitchell</i>				<i>Susan Artridge Owens</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>g</i>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<i>442x</i>						<i>Arteriosclerotic Cardiovascular Renal Disease</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Mar 19 50</i>, to <i>Dec 23 19 55</i>, that I last saw the deceased alive on <i>21 Mar 19 55</i>, and that death occurred at <i>11:00 P.M.</i> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>R. J. Farnace</i>				<i>Upper Marlboro Md</i>		<i>12-24-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>				<i>12/26/55</i>		<i>Not Culinary</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Dec. 31. 55</i>		<i>J. B. Dent</i>		<i>Bernard Hardisty</i>		<i>Galveston Md</i>	

CERTIFICATE OF DEATH

Reg. 012-100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESS

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BUREAU V. S.

RECEIVED
JAN 2 1916

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH THE CAUSE OF DEATH. IT IS THE DUTY OF THE WITNESSES TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH THE CAUSE OF DEATH. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH THE CAUSE OF DEATH. IT IS THE DUTY OF THE WITNESSES TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH THE CAUSE OF DEATH.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11509

11488

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63 Anne Arundel General Hospital</u>				STREET ADDRESS <u>R. F. D. 4</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>MAUDE</u> (First) <u>M.</u> (Middle) <u>HURLBUTT</u> (Last)				4. DATE OF DEATH <u>Dec. 5,</u> (Month) (Day) (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 26, 1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John E. Mills</u>				14. MOTHER'S MAIDEN NAME <u>Emma Bush</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>g</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Bertha S. Miles, Annapolis, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
493X IMMEDIATE CAUSE (A) <u>PNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ARTERIOSCLEROTIC HEART DISEASE with CONGESTIVE FAILURE</u>						4-5 YRS.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1 DEC</u> , 19 <u>55</u> , to <u>5 DEC</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4 DEC</u> , 19 <u>55</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward S. Beck</u>		M.D. <u>41 Southgate Ave Annapolis</u>		DATE SIGNED <u>12/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Park Cemetery Parkville, Md</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>DEC 6 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 St Paul St</u>	

RECEIVED

NOTICE: This form is to be filled out by the physician or other qualified person who has attended the deceased. It is to be filled out for all deaths, except those which are reported as "Sudden Death" or "Death in Custody". It is to be filled out for all deaths, except those which are reported as "Sudden Death" or "Death in Custody". It is to be filled out for all deaths, except those which are reported as "Sudden Death" or "Death in Custody".

1958 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

REG. NO. 15

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX
 a. Male
 b. Female

3. DATE OF DEATH

4. PLACE OF DEATH
 a. Home
 b. Hospital
 c. Nursing Home
 d. Other

5. DECEASED'S AGE (in years and months)
 a. Years
 b. Months

6. DECEASED'S OCCUPATION

7. DECEASED'S MARITAL STATUS
 a. Married
 b. Single
 c. Widowed
 d. Divorced

8. DECEASED'S BIRTH DATE (Month, day, year)

9. DECEASED'S BIRTH PLACE (City, State, Country)

10. DECEASED'S US CITIZENSHIP
 a. Naturalized
 b. Born in U.S.

11. DECEASED'S RACE

12. DECEASED'S RELIGION

13. DECEASED'S EDUCATION
 a. Less than high school
 b. High school
 c. Some college
 d. College graduate
 e. Postgraduate

14. DECEASED'S PRESENT ADDRESS (Street, City, State, Zip)

15. DECEASED'S PRESENT PHONE NUMBER

16. DECEASED'S PRESENT EMPLOYER (Name, Address, City, State, Zip)

17. DECEASED'S PRESENT SOCIAL SECURITY NUMBER

18. DECEASED'S PRESENT MARITAL STATUS
 a. Married
 b. Single
 c. Widowed
 d. Divorced

19. DECEASED'S PRESENT OCCUPATION

20. DECEASED'S PRESENT BIRTH DATE (Month, day, year)

21. DECEASED'S PRESENT BIRTH PLACE (City, State, Country)

22. DECEASED'S PRESENT US CITIZENSHIP
 a. Naturalized
 b. Born in U.S.

23. DECEASED'S PRESENT RACE

24. DECEASED'S PRESENT RELIGION

25. DECEASED'S PRESENT EDUCATION
 a. Less than high school
 b. High school
 c. Some college
 d. College graduate
 e. Postgraduate

26. DECEASED'S PRESENT ADDRESS (Street, City, State, Zip)

27. DECEASED'S PRESENT PHONE NUMBER

28. DECEASED'S PRESENT EMPLOYER (Name, Address, City, State, Zip)

29. DECEASED'S PRESENT SOCIAL SECURITY NUMBER

30. DECEASED'S PRESENT MARITAL STATUS
 a. Married
 b. Single
 c. Widowed
 d. Divorced

31. DECEASED'S PRESENT OCCUPATION

BUREAU V. S.

JEC 7 1955

RECEIVED

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11510

11520

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>			
TOWN <u>Millersville</u>				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sanas Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>James</u> <u>IRONS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 28</u> <u>19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 20, 1863</u>		9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron Construction.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Wm. Page 405 W. 21st St. Baltimore, Del.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>443X</u> IMMEDIATE CAUSE (A) <u>Hypertensive Cardio Vascular diseases</u>						<u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>General Arterio sclerosis</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/25/55</u> , 19, to <u>12/28/55</u> , 19, that I last saw the deceased alive on <u>12/26/55</u> , 19, and that death occurred at <u>1:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Gustave K. Chamberlain</u>				ADDRESS (Street, city, town, state) DATE SIGNED <u>M.D. Glen Burnie, Md.</u> <u>12/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>H. M. Jaycox</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. Cook, Inc.</u> <u>1217 St. Paul St.</u>			
DATE <u>JAN 2 1955</u>							

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11511

11521

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY NNe Arundal		MARYLAND		STATE Md.		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL and give nearest town) Crownsville		LENGTH OF STAY (In this place) 18 mo.		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore		TOWN 3401.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural give location) 1714 W. Lanvale St.			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Eva Myrtle Johnson (Brown)				4. DATE OF DEATH (Month) (Day) (Year) Dec. 24, 1955			
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb. 1, 1904	9. AGE last birthday 51 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Brown				14. MOTHER'S MAIDEN NAME Clara Henry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Percy Brown 1324 Shields Pl.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) Coronary Thrombosis						sudden	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary Tuberculosis						since Dec. 1952	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 23, 1954 , to Dec. 24, 1955 , that I last saw the deceased alive on Dec. 24, 1955 , and that death occurred at 7:30 AM , from the causes and on the date stated above.							
SIGNATURE Lucy S. Nelson				ADDRESS (Street, city, town, state) Crownsville, Md.		DATE SIGNED 12/26/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-29-55		NAME OF CEMETERY OR CREMATORY Mount Auburn		LOCATION (City, town, or county) (State) and	
24. REC'D BY REGISTRAR DEC 27 1955		REGISTRAR'S SIGNATURE H. M. Joyce		25. FUNERAL DIRECTOR'S SIGNATURE Geo. S. Nelson		ADDRESS 1348 n. Calhoun st	

ENCLOSURE

THIS OFFICE HAS RECEIVED FROM THE BUREAU OF VETERANS AFFAIRS, WASHINGTON, D. C., A COPY OF THE REPORT OF THE SURGEON GENERAL, U. S. ARMY, DATED 1915, CONCERNING THE DEATH OF THE LATE MAJOR GENERAL JOHN W. B. ...

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Reg. Dist. No.

1. USUAL RESIDENCE (House or Place)

2. Name of Deceased

3. Date of Death

4. Place of Death

5. Name of Physician

6. Cause of Death

7. Name of Hospital

8. Name of Nurse

9. Name of Doctor

10. Name of Assistant

11. Name of Coroner

12. Name of Jury

BUREAU V. 2

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DEC 29 1915

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

11512

11522

Reg. Dist. No.

1. PLACE OF DEATH - COUNTY Anne Arundel		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		CITY (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Plaza Manor Nursing Home		STREET ADDRESS (If rural, give location) Rural	
3. NAME OF DECEASED (Type or Print) Herman D. Johnson		4. DATE OF DEATH Dec. 7th 1955	
5. SEX M.		6. COLOR OR RACE Colored	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 27 Sept. 1890	
9. AGE last birthday 65 yrs.		10. If under 1 year Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John D. Johnson		14. MOTHER'S MAIDEN NAME Mary Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No. -----	
17. INFORMANT Plaza Manor N. Home Records.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Cerebral Hemorrhage		2 days.
Antecedent cause(s) (b) General Arteriosclerosis		?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

Deputy Medical Examiner

Glen Burnie, Md.

DATE SIGNED

12/7/55

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 12/10/55	NAME OF CEMETERY OR CREMATORY Holy Face	LOCATION (City, town, or county) Great Mills, Md.	(State)
DATE REC'D BY LOCAL REG 12-9-55	REGISTRAR'S SIGNATURE L. J. Lillings	24. FUNERAL DIRECTOR P.B. Robinson - Leonardtown, Md.	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 14 1955

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11523

CERTIFICATE OF DEATH

11513²⁸

Reg. Dist. No. 261

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Summer Set</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crownsville, Md.</u>		LENGTH OF STAY (In this place) <u>4-14-55 to 12-17-55</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Summerset, Md.</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hosp.</u>				STREET ADDRESS (If rural give location) <u>Summer Set, Md.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Sarah</u> <u>Hannah</u> <u>Johnson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12-17-55</u> <u>19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1885</u>		9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(last name) Marshall</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Record Crownsville State Hosp.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis, Far advanced</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-14-55</u>, 19....., to <u>12-17-55</u>, 19....., that I last saw the deceased alive on <u>12-17-55</u>, 19....., and that death occurred at <u>10:55A</u> M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) DATE SIGNED <u>12-17-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 22-55</u>		NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		LOCATION (City, town, or county) (State) <u>Marion St. Md</u>	
24. REC'D BY REGISTRAR <u>12-22-55</u>		REGISTRAR'S SIGNATURE <u>Hebbie D. Payne</u> <u>Latherine M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Howard Marion Md</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JUDGE		14. SIGNATURE OF CLERK		15. SIGNATURE OF SHERIFF	
16. SIGNATURE OF DEPUTY SHERIFF		17. SIGNATURE OF CONSTABLE		18. SIGNATURE OF JURY	
19. SIGNATURE OF GRAND JURY		20. SIGNATURE OF COURT		21. SIGNATURE OF JUDGE	
22. SIGNATURE OF CLERK		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF DEPUTY SHERIFF	
25. SIGNATURE OF CONSTABLE		26. SIGNATURE OF JURY		27. SIGNATURE OF GRAND JURY	
28. SIGNATURE OF COURT		29. SIGNATURE OF JUDGE		30. SIGNATURE OF CLERK	
31. SIGNATURE OF SHERIFF		32. SIGNATURE OF DEPUTY SHERIFF		33. SIGNATURE OF CONSTABLE	
34. SIGNATURE OF JURY		35. SIGNATURE OF GRAND JURY		36. SIGNATURE OF COURT	
37. SIGNATURE OF JUDGE		38. SIGNATURE OF CLERK		39. SIGNATURE OF SHERIFF	
40. SIGNATURE OF DEPUTY SHERIFF		41. SIGNATURE OF CONSTABLE		42. SIGNATURE OF JURY	
43. SIGNATURE OF GRAND JURY		44. SIGNATURE OF COURT		45. SIGNATURE OF JUDGE	
46. SIGNATURE OF CLERK		47. SIGNATURE OF SHERIFF		48. SIGNATURE OF DEPUTY SHERIFF	
49. SIGNATURE OF CONSTABLE		50. SIGNATURE OF JURY		51. SIGNATURE OF GRAND JURY	
52. SIGNATURE OF COURT		53. SIGNATURE OF JUDGE		54. SIGNATURE OF CLERK	
55. SIGNATURE OF SHERIFF		56. SIGNATURE OF DEPUTY SHERIFF		57. SIGNATURE OF CONSTABLE	
58. SIGNATURE OF JURY		59. SIGNATURE OF GRAND JURY		60. SIGNATURE OF COURT	
61. SIGNATURE OF JUDGE		62. SIGNATURE OF CLERK		63. SIGNATURE OF SHERIFF	
64. SIGNATURE OF DEPUTY SHERIFF		65. SIGNATURE OF CONSTABLE		66. SIGNATURE OF JURY	
67. SIGNATURE OF GRAND JURY		68. SIGNATURE OF COURT		69. SIGNATURE OF JUDGE	
70. SIGNATURE OF CLERK		71. SIGNATURE OF SHERIFF		72. SIGNATURE OF DEPUTY SHERIFF	
73. SIGNATURE OF CONSTABLE		74. SIGNATURE OF JURY		75. SIGNATURE OF GRAND JURY	
76. SIGNATURE OF COURT		77. SIGNATURE OF JUDGE		78. SIGNATURE OF CLERK	
79. SIGNATURE OF SHERIFF		80. SIGNATURE OF DEPUTY SHERIFF		81. SIGNATURE OF CONSTABLE	
82. SIGNATURE OF JURY		83. SIGNATURE OF GRAND JURY		84. SIGNATURE OF COURT	
85. SIGNATURE OF JUDGE		86. SIGNATURE OF CLERK		87. SIGNATURE OF SHERIFF	
88. SIGNATURE OF DEPUTY SHERIFF		89. SIGNATURE OF CONSTABLE		90. SIGNATURE OF JURY	
91. SIGNATURE OF GRAND JURY		92. SIGNATURE OF COURT		93. SIGNATURE OF JUDGE	
94. SIGNATURE OF CLERK		95. SIGNATURE OF SHERIFF		96. SIGNATURE OF DEPUTY SHERIFF	
97. SIGNATURE OF CONSTABLE		98. SIGNATURE OF JURY		99. SIGNATURE OF GRAND JURY	
100. SIGNATURE OF COURT		101. SIGNATURE OF JUDGE		102. SIGNATURE OF CLERK	
103. SIGNATURE OF SHERIFF		104. SIGNATURE OF DEPUTY SHERIFF		105. SIGNATURE OF CONSTABLE	
106. SIGNATURE OF JURY		107. SIGNATURE OF GRAND JURY		108. SIGNATURE OF COURT	
109. SIGNATURE OF JUDGE		110. SIGNATURE OF CLERK		111. SIGNATURE OF SHERIFF	
112. SIGNATURE OF DEPUTY SHERIFF		113. SIGNATURE OF CONSTABLE		114. SIGNATURE OF JURY	
115. SIGNATURE OF GRAND JURY		116. SIGNATURE OF COURT		117. SIGNATURE OF JUDGE	
118. SIGNATURE OF CLERK		119. SIGNATURE OF SHERIFF		120. SIGNATURE OF DEPUTY SHERIFF	
121. SIGNATURE OF CONSTABLE		122. SIGNATURE OF JURY		123. SIGNATURE OF GRAND JURY	
124. SIGNATURE OF COURT		125. SIGNATURE OF JUDGE		126. SIGNATURE OF CLERK	
127. SIGNATURE OF SHERIFF		128. SIGNATURE OF DEPUTY SHERIFF		129. SIGNATURE OF CONSTABLE	
130. SIGNATURE OF JURY		131. SIGNATURE OF GRAND JURY		132. SIGNATURE OF COURT	
133. SIGNATURE OF JUDGE		134. SIGNATURE OF CLERK		135. SIGNATURE OF SHERIFF	
136. SIGNATURE OF DEPUTY SHERIFF		137. SIGNATURE OF CONSTABLE		138. SIGNATURE OF JURY	
139. SIGNATURE OF GRAND JURY		140. SIGNATURE OF COURT		141. SIGNATURE OF JUDGE	
142. SIGNATURE OF CLERK		143. SIGNATURE OF SHERIFF		144. SIGNATURE OF DEPUTY SHERIFF	
145. SIGNATURE OF CONSTABLE		146. SIGNATURE OF JURY		147. SIGNATURE OF GRAND JURY	
148. SIGNATURE OF COURT		149. SIGNATURE OF JUDGE		150. SIGNATURE OF CLERK	
151. SIGNATURE OF SHERIFF		152. SIGNATURE OF DEPUTY SHERIFF		153. SIGNATURE OF CONSTABLE	
154. SIGNATURE OF JURY		155. SIGNATURE OF GRAND JURY		156. SIGNATURE OF COURT	
157. SIGNATURE OF JUDGE		158. SIGNATURE OF CLERK		159. SIGNATURE OF SHERIFF	
160. SIGNATURE OF DEPUTY SHERIFF		161. SIGNATURE OF CONSTABLE		162. SIGNATURE OF JURY	
163. SIGNATURE OF GRAND JURY		164. SIGNATURE OF COURT		165. SIGNATURE OF JUDGE	
166. SIGNATURE OF CLERK		167. SIGNATURE OF SHERIFF		168. SIGNATURE OF DEPUTY SHERIFF	
169. SIGNATURE OF CONSTABLE		170. SIGNATURE OF JURY		171. SIGNATURE OF GRAND JURY	
172. SIGNATURE OF COURT		173. SIGNATURE OF JUDGE		174. SIGNATURE OF CLERK	
175. SIGNATURE OF SHERIFF		176. SIGNATURE OF DEPUTY SHERIFF		177. SIGNATURE OF CONSTABLE	
178. SIGNATURE OF JURY		179. SIGNATURE OF GRAND JURY		180. SIGNATURE OF COURT	
181. SIGNATURE OF JUDGE		182. SIGNATURE OF CLERK		183. SIGNATURE OF SHERIFF	
184. SIGNATURE OF DEPUTY SHERIFF		185. SIGNATURE OF CONSTABLE		186. SIGNATURE OF JURY	
187. SIGNATURE OF GRAND JURY		188. SIGNATURE OF COURT		189. SIGNATURE OF JUDGE	
190. SIGNATURE OF CLERK		191. SIGNATURE OF SHERIFF		192. SIGNATURE OF DEPUTY SHERIFF	
193. SIGNATURE OF CONSTABLE		194. SIGNATURE OF JURY		195. SIGNATURE OF GRAND JURY	
196. SIGNATURE OF COURT		197. SIGNATURE OF JUDGE		198. SIGNATURE OF CLERK	
199. SIGNATURE OF SHERIFF		200. SIGNATURE OF DEPUTY SHERIFF		201. SIGNATURE OF CONSTABLE	
202. SIGNATURE OF JURY		203. SIGNATURE OF GRAND JURY		204. SIGNATURE OF COURT	
205. SIGNATURE OF JUDGE		206. SIGNATURE OF CLERK		207. SIGNATURE OF SHERIFF	
208. SIGNATURE OF DEPUTY SHERIFF		209. SIGNATURE OF CONSTABLE		210. SIGNATURE OF JURY	
211. SIGNATURE OF GRAND JURY		212. SIGNATURE OF COURT		213. SIGNATURE OF JUDGE	
214. SIGNATURE OF CLERK		215. SIGNATURE OF SHERIFF		216. SIGNATURE OF DEPUTY SHERIFF	
217. SIGNATURE OF CONSTABLE		218. SIGNATURE OF JURY		219. SIGNATURE OF GRAND JURY	
220. SIGNATURE OF COURT		221. SIGNATURE OF JUDGE		222. SIGNATURE OF CLERK	
223. SIGNATURE OF SHERIFF		224. SIGNATURE OF DEPUTY SHERIFF		225. SIGNATURE OF CONSTABLE	
226. SIGNATURE OF JURY		227. SIGNATURE OF GRAND JURY		228. SIGNATURE OF COURT	
229. SIGNATURE OF JUDGE		230. SIGNATURE OF CLERK		231. SIGNATURE OF SHERIFF	
232. SIGNATURE OF DEPUTY SHERIFF		233. SIGNATURE OF CONSTABLE		234. SIGNATURE OF JURY	
235. SIGNATURE OF GRAND JURY		236. SIGNATURE OF COURT		237. SIGNATURE OF JUDGE	
238. SIGNATURE OF CLERK		239. SIGNATURE OF SHERIFF		240. SIGNATURE OF DEPUTY SHERIFF	
241. SIGNATURE OF CONSTABLE		242. SIGNATURE OF JURY		243. SIGNATURE OF GRAND JURY	
244. SIGNATURE OF COURT		245. SIGNATURE OF JUDGE		246. SIGNATURE OF CLERK	
247. SIGNATURE OF SHERIFF		248. SIGNATURE OF DEPUTY SHERIFF		249. SIGNATURE OF CONSTABLE	
250. SIGNATURE OF JURY		251. SIGNATURE OF GRAND JURY		252. SIGNATURE OF COURT	
253. SIGNATURE OF JUDGE		254. SIGNATURE OF CLERK		255. SIGNATURE OF SHERIFF	
256. SIGNATURE OF DEPUTY SHERIFF		257. SIGNATURE OF CONSTABLE		258. SIGNATURE OF JURY	
259. SIGNATURE OF GRAND JURY		260. SIGNATURE OF COURT		261. SIGNATURE OF JUDGE	
262. SIGNATURE OF CLERK		263. SIGNATURE OF SHERIFF		264. SIGNATURE OF DEPUTY SHERIFF	
265. SIGNATURE OF CONSTABLE		266. SIGNATURE OF JURY		267. SIGNATURE OF GRAND JURY	
268. SIGNATURE OF COURT		269. SIGNATURE OF JUDGE		270. SIGNATURE OF CLERK	
271. SIGNATURE OF SHERIFF		272. SIGNATURE OF DEPUTY SHERIFF		273. SIGNATURE OF CONSTABLE	
274. SIGNATURE OF JURY		275. SIGNATURE OF GRAND JURY		276. SIGNATURE OF COURT	
277. SIGNATURE OF JUDGE		278. SIGNATURE OF CLERK		279. SIGNATURE OF SHERIFF	
280. SIGNATURE OF DEPUTY SHERIFF		281. SIGNATURE OF CONSTABLE		282. SIGNATURE OF JURY	
283. SIGNATURE OF GRAND JURY		284. SIGNATURE OF COURT		285. SIGNATURE OF JUDGE	
286. SIGNATURE OF CLERK		287. SIGNATURE OF SHERIFF		288. SIGNATURE OF DEPUTY SHERIFF	
289. SIGNATURE OF CONSTABLE		290. SIGNATURE OF JURY		291. SIGNATURE OF GRAND JURY	
292. SIGNATURE OF COURT		293. SIGNATURE OF JUDGE		294. SIGNATURE OF CLERK	
295. SIGNATURE OF SHERIFF		296. SIGNATURE OF DEPUTY SHERIFF		297. SIGNATURE OF CONSTABLE	
298. SIGNATURE OF JURY		299. SIGNATURE OF GRAND JURY		300. SIGNATURE OF COURT	

BUREAU V. S.

RECEIVED

JEC 77 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11524

CERTIFICATE OF DEATH

11514

Reg. Dist. No. 23

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Linthicum Heights</u>				TOWN <u>Linthicum Heights</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>316 Maple Road</u>				STREET ADDRESS (If rural give location) <u>316 Maple Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MYRTLE</u>		(Middle) <u>T.</u>		(Last) <u>JOLLYE</u>		(Month) (Day) (Year) <u>Dec. 4, 1955</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>Feb. 24, 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Johns Hopkins Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Emory Smith</u>				14. MOTHER'S MAIDEN NAME <u>Artemisia Williamson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Mrs. Mildred Carter, Linthicum Hts</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 4, 1955</u> , to <u>Dec 4, 1955</u> , that I last saw the deceased alive on <u>Dec 4, 1955</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Louis T. Ravey</u>				DATE SIGNED <u>12/5/55</u>			
ADDRESS (Street, city, town, state) <u>1844 W. North Ave Baltimore Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>12/5/55</u>		NAME OF CEMETERY OR CREMATORY <u>Millers Cemetery</u>		LOCATION (city, town, or county) (State) <u>Mullins, South Carolina</u>	
24. REC'D BY REGISTRAR <u>DEC 6 1955</u>		REGISTRAR'S SIGNATURE <u>Dr. Caldwell Woodruff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Book, Inc.</u>		ADDRESS <u>1217 St. Paul Street</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11515

11525 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Crownsville</u>		<u>23 yrs. 1 mos.</u>		TOWN <u>Chesapeake Beach</u>		<u>04X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>None listed</u> ✓			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Compton</u>				<u>Jones</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Male</u>		<u>Negro</u>		<u>Married</u>		<u>1892?</u>	
						9. AGE last birthday <u>63?</u> yrs.	
						IF UNDER 1 YEAR <u>12</u> Months <u>26</u> Days <u>19</u> Hours <u>55</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>George Jones</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service) <u>Unk.</u>				16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>331X Cerebrovascular Accident</u>						<u>12 days</u>	
DUE TO ANTECEDENT CAUSE(S) (B) <u>Cerebral Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypostatic Pneumonia</u>						<u>2 days</u>	
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/21/48</u> , to <u>12/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/26</u> , 19 <u>55</u> , and that death occurred at <u>3:55 p.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>L. Benedict, M. D.</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>			
DATE <u>12/28/55</u>				DATE SIGNED <u>12/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>12/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Edmonds</u>		LOCATION (City, town, or county) (State) <u>Calvert Co.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>H M Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Pinkney C. Sewell Jr. Funeral Home</u>		ADDRESS	

11489 CERTIFICATE OF DEATH

Reg. Dist. No. 21

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Annapolis</i>		<i>Life</i>		TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>19 N. Woodlawn Av.</i>				STREET ADDRESS (If rural give location) <i>19 N. Woodlawn Ave.</i>			
3. NAME OF DECEASED (First) (Middle) (Last) <i>JAMES EDWARD JONES</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>DEC. 15 1955</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W</i>	8. DATE OF BIRTH <i>AUG. 2, 1879</i>	9. AGE last birthday <i>76</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FIREMAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Naval Academy</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Richard Jones</i>				14. MOTHER'S MAIDEN NAME <i>Mary E. Holland</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No.</i>		16. SOCIAL SECURITY NO. <i>(If Yes, give war or dates of service)</i>		17. INFORMANT & ADDRESS <i>Son - Richard - same address</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.1</i>						<i>5 hrs.</i>	
IMMEDIATE CAUSE (A) <i>Acute myocardial infarction</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Pulmonary Emphysema</i>						<i>20 yrs.</i>	
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>AUGUST, 1955</i> , to <i>15 DEC., 1955</i> , that I last saw the deceased alive on <i>15 DEC., 1955</i> , and that death occurred at <i>7:45</i> M., from the causes and on the date stated above. <i>12/15/55</i>							
SIGNATURE <i>John H. Hedeman</i>				ADDRESS (Street, city, town, state) DATE SIGNED <i>M.D. 90 Cathedral St., Annapolis, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-17-55</i>		NAME OF CEMETERY OR CREMATORY <i>St Marys</i>		LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>	
24. REC'D BY REGISTRAR DATE <i>Dec. 17, 1955</i>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md.</i>	

NOTIFICATION

1. This is to certify that the person named in the accompanying report has died, and that the death has been reported to the Bureau of Health Statistics, State of Maryland, and that the death has been recorded in the State of Maryland.

2. The death has been reported to the Bureau of Health Statistics, State of Maryland, and that the death has been recorded in the State of Maryland.

3. The death has been reported to the Bureau of Health Statistics, State of Maryland, and that the death has been recorded in the State of Maryland.

4. The death has been reported to the Bureau of Health Statistics, State of Maryland, and that the death has been recorded in the State of Maryland.

5. The death has been reported to the Bureau of Health Statistics, State of Maryland, and that the death has been recorded in the State of Maryland.

6. The death has been reported to the Bureau of Health Statistics, State of Maryland, and that the death has been recorded in the State of Maryland.

7. The death has been reported to the Bureau of Health Statistics, State of Maryland, and that the death has been recorded in the State of Maryland.

8. The death has been reported to the Bureau of Health Statistics, State of Maryland, and that the death has been recorded in the State of Maryland.

9. The death has been reported to the Bureau of Health Statistics, State of Maryland, and that the death has been recorded in the State of Maryland.

10. The death has been reported to the Bureau of Health Statistics, State of Maryland, and that the death has been recorded in the State of Maryland.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Dec. 10, 1975

1. Name of deceased

2. Place of death

3. Date of death

4. Sex

5. Race

6. Age

7. Marital status

8. Cause of death

9. Place of birth

10. Date of birth

11. Date of death

12. Date of death

13. Date of death

14. Date of death

15. Date of death

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80. Date of death

BUREAU V. S.

DEC 10 1975

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11517

11490 **CERTIFICATE OF DEATH**Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>10</u> TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>63</u> <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location) <u>1023 West Street</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Mary</u>		(Middle) <u>P</u>		(Last) <u>Jones</u>	
4. DATE OF DEATH (Month) <u>December</u> (Day) <u>9</u> (Year) <u>1955</u>							
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>DECEMBER 8, 1955</u>	9. AGE last birthday <u>—</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>— — — —</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>— — — —</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William I Jones</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Brandow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>9</u> (If Yes, give war or dates of service) <u>— — — —</u>		16. SOCIAL SECURITY NO. <u>— — — — —</u>		17. INFORMANT & ADDRESS <u>Mr Wm I Jones, Father- same as # 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>776x</u> IMMEDIATE CAUSE (A) <u>prematurity (30 wks.)</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/8/55</u> , 19 <u>—</u> , to <u>12/9/55</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>12/9/55</u> 19 <u>—</u> , and that death occurred at <u>2:35 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D. <u>Annapolis, Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>12/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-12-55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR <u>12-12-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Hopping Funeral Home Annapolis, Md.</u>			

2045192322

CERTIFICATE OF DEATH

1. DECEASED PERSON'S NAME (PRINT OR TYPE)

2. SEX (M or F) 3. AGE (Years, Months, Days)

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. OCCUPATION (Print or Type)

7. CAUSE OF DEATH (Print or Type)

8. PLACE OF DEATH (Print or Type)

9. DATE OF DEATH (Print or Type)

10. SIGNATURE OF PHYSICIAN (Print or Type)

11. SIGNATURE OF REGISTRAR (Print or Type)

12. SIGNATURE OF WITNESS (Print or Type)

13. SIGNATURE OF DECEASED (Print or Type)

14. SIGNATURE OF NEXT OF KIN (Print or Type)

15. SIGNATURE OF OTHER (Print or Type)

16. SIGNATURE OF OTHER (Print or Type)

17. SIGNATURE OF OTHER (Print or Type)

18. SIGNATURE OF OTHER (Print or Type)

19. SIGNATURE OF OTHER (Print or Type)

20. SIGNATURE OF OTHER (Print or Type)

21. SIGNATURE OF OTHER (Print or Type)

22. SIGNATURE OF OTHER (Print or Type)

23. SIGNATURE OF OTHER (Print or Type)

24. SIGNATURE OF OTHER (Print or Type)

25. SIGNATURE OF OTHER (Print or Type)

1. DECEASED PERSON'S NAME (PRINT OR TYPE)

2. SEX (M or F) 3. AGE (Years, Months, Days)

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. OCCUPATION (Print or Type)

7. CAUSE OF DEATH (Print or Type)

8. PLACE OF DEATH (Print or Type)

9. DATE OF DEATH (Print or Type)

10. SIGNATURE OF PHYSICIAN (Print or Type)

11. SIGNATURE OF REGISTRAR (Print or Type)

12. SIGNATURE OF WITNESS (Print or Type)

13. SIGNATURE OF DECEASED (Print or Type)

14. SIGNATURE OF NEXT OF KIN (Print or Type)

15. SIGNATURE OF OTHER (Print or Type)

16. SIGNATURE OF OTHER (Print or Type)

17. SIGNATURE OF OTHER (Print or Type)

18. SIGNATURE OF OTHER (Print or Type)

19. SIGNATURE OF OTHER (Print or Type)

20. SIGNATURE OF OTHER (Print or Type)

21. SIGNATURE OF OTHER (Print or Type)

22. SIGNATURE OF OTHER (Print or Type)

23. SIGNATURE OF OTHER (Print or Type)

BUREAU V. S.

DEC 13 1955

RECEIVED

ENCLOSURE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

11526

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

11518

Reg. Dist. No. 27

Item 23, Film G190 12-29-55 et

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Illinois</u> COUNTY <u>Cook</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glen Burnie (rural)</u> LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chicago</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Rt. #301</u>		STREET ADDRESS (If rural, give location) <u>69 East 79th Street</u>	
3. NAME OF DECEASED (First) <u>Peter</u> (Middle) <u>P.</u> (Last) <u>Jonkus</u>		4. DATE OF DEATH (Month) <u>December</u> (Day) <u>13</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>7 August 1917</u>
9. AGE last birthday <u>36</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Army</u>
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Jonkus</u>		14. MOTHER'S MAIDEN NAME <u>Marie (maiden name unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT <u>Service record, U.S. Army</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
<u>825X</u> Immediate cause (a) <u>Multiple skull fractures with traumatic destruction of brain</u> Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, office bldg., etc.) <u>Rt. 301</u> (CITY OR TOWN) <u>Glen Burnie</u> (COUNTY) <u>Anne Arundel</u> (STATE) <u>Md.</u>			
TIME (Month) (Day) (Year) (Hour) INJURY <u>December 13 1955</u> 1:00 am		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>automobile accident</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Ernest H. Pancher, M.D.</u>		ADDRESS <u>Medical Examiner - Glen Burnie, Md.</u> DATE SIGNED <u>12/13/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Unknown</u> NAME OF CEMETERY OR CREMATORY <u>Unknown</u> LOCATION (City, town, or county) <u>Chicago, Ill</u> (State) <u>Unknown</u>	
DATE REC'D BY LOCAL REG. <u>13 December 1955</u>		24. FUNERAL DIRECTOR <u>W.L. SAYLOR, 1ST LT, MSC</u> ADDRESS <u>Unknown</u>	

BUREAU V. S.

DEC 19 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11527

CERTIFICATE OF DEATH

11519

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Millersville (Rural)</u>		LENGTH OF STAY (in this place) <u>13 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Gambrills (Rural)</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sann's Nursing Home</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>John</u> <u>Kurtz</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec.</u> <u>31</u> , <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12/26/ 1861</u>		9. AGE last birthday <u>94</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u> <u>Kurtz</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>25 Clarendon Ave</u> <u>Mrs John Kurtz, Baltimore 8, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>430.1 Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 Hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Nov</u> , 19 <u>54</u> , to <u>Dec 31</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 22</u> , 19 <u>55</u> , and that death occurred at <u>10:30</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Edmund J. Merritt</u>				ADDRESS (Street, city, town, state) <u>Gambrills Md</u>		DATE SIGNED <u>1-1-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/3/56</u>		NAME OF CEMETERY OR CREMATORY <u>Our Lady of Fields Cem</u>		LOCATION (City, town, or county) <u>Millersville, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>H. M. Jaynes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Kirkley</u> <u>Hopping & Kirkley, Glen Burnie, Md.</u>			
DATE <u>1</u> <u>1956</u>							

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BUREAU V. S.

JAN 4 1956

RECEIVED
JAN 4 1956

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11520

11528 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Millersville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> 3Y01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sann's Nursing Home</u>				STREET ADDRESS (If rural give location) <u>900 Mavin st.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>IDA M. LEMEN</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>12-14-55</u> 19			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>8-17-82</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>hwi</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>home</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>JAMES SMITH</u>				14. MOTHER'S MAIDEN NAME: <u>ELLEN DANIELS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Family - above</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						3 hrs	
443X IMMEDIATE CAUSE (A) <u>Cerebral Accident</u> DUE TO							
ANTECEDENT CAUSE (B) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO						4 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Dec 14</u> , 19 <u>55</u> that I last saw the deceased alive on <u>Dec 12</u> , 19 <u>55</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Edward J. Bennett</u> ADDRESS <u>Baltimore Md</u> DATE SIGNED <u>12-31-55</u> M. D. <u>Baltimore Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>12-17-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>JAN 3 1956</u>		REGISTRAR'S SIGNATURE <u>L. M. Joyce</u>		24. FUNERAL DIRECTOR ADDRESS <u>McCully Funeral home, 130 E. Fort av. Balto.</u>			

BUREAU V. S.

JAN 4 1956

RECEIVED

11521

MARYLAND STATE DEPARTMENT OF HEALTH

11529

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH - COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Same</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Severna Park</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
TOWN <u>Light St.</u>				TOWN <u>Same</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Barleigh Heights</u>				STREET ADDRESS (If rural, give location) <u>Same</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Grace Gertrude Linkenhoger</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 13 1955</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, MARRIED <u>WIDOWED</u> (Specify)		8. DATE OF BIRTH <u>10/2/94</u>	
9. AGE last birthday <u>61</u> yrs.		10. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		11. BIRTHPLACE (State or foreign country) <u>Richmond Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Bellam</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Harris</u>			
15. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Abraham Linkenhoger, (husband)</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>Dec. 16, 1955</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
HOW DID INJURY OCCUR?							
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .							
SIGNATURE <u>Gustave H. Buckner</u> Deputy Medical Examiner				DATE SIGNED <u>12/14/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>				DATE THEREOF <u>Dec. 16, 1955</u>			
NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>				LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>			
24. FUNERAL DIRECTOR <u>W. H. King</u>				ADDRESS <u>Glen Burnie, Md.</u>			
DATE REC'D BY LOCAL REG. <u>Dec-16-1955</u>				REGISTRAR'S SIGNATURE <u>L. J. Dealba</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 21 1935

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11530

CERTIFICATE OF DEATH

11522

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL and give nearest town) Crownsville		LENGTH OF STAY (In this place) 2 yrs. 5 mos. 23 days		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore City		301-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital		STREET ADDRESS (If rural give location) 1352 N. Calhoun Street					
3. NAME OF DECEASED (First) (Middle) (Last) Beatrice Maynard				4. DATE OF DEATH (Month) (Day) (Year) 12 29 19 55			
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Dec. 1909	9. AGE last birthday 46 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Undetermined		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT & ADDRESS Hospital Records			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) Brain Hemorrhage						6 days	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension						Unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hyperpyrexia							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/6, 19 55, to 12/29/19 55, that I last saw the deceased alive on 12/29/19 55, and that death occurred at 7:30a.m. from the causes and on the date stated above.							
SIGNATURE <i>Harold Kaper Reissman</i> M.D.				ADDRESS (Street, city, town, state) Crownsville, Md.		DATE SIGNED 12/29/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-5-56		NAME OF CEMETERY OR CREMATORY Mt. Calvary		LOCATION (City, town, or county) (State) A.A. Co.	
24. REC'D BY REGISTRAR AN 2 1955		REGISTRAR'S SIGNATURE <i>H. M. Jaynes</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Geo. D. Nelson</i>		ADDRESS 1348 N. Calhoun St	

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BUREAU V. S.

11530
CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1. NAME OF DECEASED John A. Smith		2. SEX Male		3. AGE 65	
4. DATE OF DEATH Jan 1, 1966		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF DECEASED John A. Smith	
10. SIGNATURE OF WITNESSES John A. Smith		11. SIGNATURE OF PHYSICIAN John A. Smith		12. SIGNATURE OF CLERK John A. Smith	
13. SIGNATURE OF DECEASED John A. Smith		14. SIGNATURE OF WITNESSES John A. Smith		15. SIGNATURE OF PHYSICIAN John A. Smith	
16. SIGNATURE OF DECEASED John A. Smith		17. SIGNATURE OF WITNESSES John A. Smith		18. SIGNATURE OF PHYSICIAN John A. Smith	
19. SIGNATURE OF DECEASED John A. Smith		20. SIGNATURE OF WITNESSES John A. Smith		21. SIGNATURE OF PHYSICIAN John A. Smith	
22. SIGNATURE OF DECEASED John A. Smith		23. SIGNATURE OF WITNESSES John A. Smith		24. SIGNATURE OF PHYSICIAN John A. Smith	
25. SIGNATURE OF DECEASED John A. Smith		26. SIGNATURE OF WITNESSES John A. Smith		27. SIGNATURE OF PHYSICIAN John A. Smith	
28. SIGNATURE OF DECEASED John A. Smith		29. SIGNATURE OF WITNESSES John A. Smith		30. SIGNATURE OF PHYSICIAN John A. Smith	
31. SIGNATURE OF DECEASED John A. Smith		32. SIGNATURE OF WITNESSES John A. Smith		33. SIGNATURE OF PHYSICIAN John A. Smith	
34. SIGNATURE OF DECEASED John A. Smith		35. SIGNATURE OF WITNESSES John A. Smith		36. SIGNATURE OF PHYSICIAN John A. Smith	
37. SIGNATURE OF DECEASED John A. Smith		38. SIGNATURE OF WITNESSES John A. Smith		39. SIGNATURE OF PHYSICIAN John A. Smith	
40. SIGNATURE OF DECEASED John A. Smith		41. SIGNATURE OF WITNESSES John A. Smith		42. SIGNATURE OF PHYSICIAN John A. Smith	
43. SIGNATURE OF DECEASED John A. Smith		44. SIGNATURE OF WITNESSES John A. Smith		45. SIGNATURE OF PHYSICIAN John A. Smith	
46. SIGNATURE OF DECEASED John A. Smith		47. SIGNATURE OF WITNESSES John A. Smith		48. SIGNATURE OF PHYSICIAN John A. Smith	
49. SIGNATURE OF DECEASED John A. Smith		50. SIGNATURE OF WITNESSES John A. Smith		51. SIGNATURE OF PHYSICIAN John A. Smith	
52. SIGNATURE OF DECEASED John A. Smith		53. SIGNATURE OF WITNESSES John A. Smith		54. SIGNATURE OF PHYSICIAN John A. Smith	
55. SIGNATURE OF DECEASED John A. Smith		56. SIGNATURE OF WITNESSES John A. Smith		57. SIGNATURE OF PHYSICIAN John A. Smith	
58. SIGNATURE OF DECEASED John A. Smith		59. SIGNATURE OF WITNESSES John A. Smith		60. SIGNATURE OF PHYSICIAN John A. Smith	
61. SIGNATURE OF DECEASED John A. Smith		62. SIGNATURE OF WITNESSES John A. Smith		63. SIGNATURE OF PHYSICIAN John A. Smith	
64. SIGNATURE OF DECEASED John A. Smith		65. SIGNATURE OF WITNESSES John A. Smith		66. SIGNATURE OF PHYSICIAN John A. Smith	
67. SIGNATURE OF DECEASED John A. Smith		68. SIGNATURE OF WITNESSES John A. Smith		69. SIGNATURE OF PHYSICIAN John A. Smith	
70. SIGNATURE OF DECEASED John A. Smith		71. SIGNATURE OF WITNESSES John A. Smith		72. SIGNATURE OF PHYSICIAN John A. Smith	
73. SIGNATURE OF DECEASED John A. Smith		74. SIGNATURE OF WITNESSES John A. Smith		75. SIGNATURE OF PHYSICIAN John A. Smith	
76. SIGNATURE OF DECEASED John A. Smith		77. SIGNATURE OF WITNESSES John A. Smith		78. SIGNATURE OF PHYSICIAN John A. Smith	
79. SIGNATURE OF DECEASED John A. Smith		80. SIGNATURE OF WITNESSES John A. Smith		81. SIGNATURE OF PHYSICIAN John A. Smith	
82. SIGNATURE OF DECEASED John A. Smith		83. SIGNATURE OF WITNESSES John A. Smith		84. SIGNATURE OF PHYSICIAN John A. Smith	
85. SIGNATURE OF DECEASED John A. Smith		86. SIGNATURE OF WITNESSES John A. Smith		87. SIGNATURE OF PHYSICIAN John A. Smith	
88. SIGNATURE OF DECEASED John A. Smith		89. SIGNATURE OF WITNESSES John A. Smith		90. SIGNATURE OF PHYSICIAN John A. Smith	
91. SIGNATURE OF DECEASED John A. Smith		92. SIGNATURE OF WITNESSES John A. Smith		93. SIGNATURE OF PHYSICIAN John A. Smith	
94. SIGNATURE OF DECEASED John A. Smith		95. SIGNATURE OF WITNESSES John A. Smith		96. SIGNATURE OF PHYSICIAN John A. Smith	
97. SIGNATURE OF DECEASED John A. Smith		98. SIGNATURE OF WITNESSES John A. Smith		99. SIGNATURE OF PHYSICIAN John A. Smith	
100. SIGNATURE OF DECEASED John A. Smith		101. SIGNATURE OF WITNESSES John A. Smith		102. SIGNATURE OF PHYSICIAN John A. Smith	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11523

11491

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		STATE <i>Md.</i> COUNTY <i>C.A.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
CITY OR TOWN <i>Annapolis</i>		LENGTH OF STAY (in this place)		STREET ADDRESS <i>Browns Woods Md.</i>		STREET ADDRESS (If rural give location) <i>Browns Woods Md.</i>	
3. NAME OF DECEASED (Type or Print) <i>Charles</i>				4. DATE OF DEATH <i>12 22 19 55</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Col</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>		8. DATE OF BIRTH <i>2-14-1889</i>	
9. AGE last birthday <i>66</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>C.A. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Henry Maynard</i>				14. MOTHER'S MAIDEN NAME <i>Felicia Stansbury</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>7-112</i>		17. INFORMANT & ADDRESS <i>Rene Maynard - Browns Woods</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <i>Congestive Cardiac Failure</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<i>25 minutes</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12-21-55</i>, to <i>12-22-55</i>, that I last saw the deceased alive on <i>12-20-55</i>, and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>A. T. Allen</i>				DATE SIGNED <i>12-23-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-25-55</i>		NAME OF CEMETERY OR CREMATORY <i>Broad Neck</i>		LOCATION (City, town, or county) (State) <i>Skidmore, Md.</i>	
24. REC'D BY REGISTRAR <i>DEC 28 1955</i>		REGISTRAR'S SIGNATURE <i>Wm. J. French</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese</i>			
DATE				ADDRESS <i>188 Wash St. Annapolis</i>			

James Smith

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Dr. Charles C. Conner.

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BUREAU V. S.

DEC 29 1955

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Dec 22-20-51

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11524

11492

CERTIFICATE OF DEATH

Reg. Dist. No. 21

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville, Md.</u>		LENGTH OF STAY (in this place) <u>14 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Davidsonville Md</u>		TOWN <u>Davidsonville Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel Gen Hosp.</u>		STREET ADDRESS (If rural give location) <u>Davidsonville Md.</u>					
3. NAME OF DECEASED (Type or Print) <u>Last</u> <u>McAuliffe</u> <u>John</u> <u>Elmer</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>March 23, 1915</u>	9. AGE last birthday <u>40</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u>55</u> Min. <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coppersmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship Building</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. McAuliffe</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>212 09-2108</u>		17. INFORMANT & ADDRESS <u>Davidsonville</u> <u>Mrs John A. McAuliffe, Md.</u>			
18. MEDICAL CERTIFICATION				19. INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u></u> DUE TO ANTECEDENT CAUSE(S) (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>U</u>		19b. MAJOR FINDINGS OF OPERATION		19c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work					
22. I hereby certify that I attended the deceased from <u>Dec 4, 1955</u> , to <u>Dec 4, 1955</u> , that I last saw the deceased alive on <u>Dec 4, 1955</u> , and that death occurred at <u>12:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Emily H. Whelan</u> M.D.				ADDRESS (Street, city, town, state) <u>Lothian, Md.</u>		DATE SIGNED <u>12-4, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>St Mary's Cem.</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
24. REC'D BY REGISTRAR <u>John J. L...</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. L...</u>		ADDRESS <u>St. Hollins</u>	

20070222M

RECEIVED
BUREAU V. S.
DEC 7 1955

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

REG. NO. 1198

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF REGISTRAR

18. SIGNATURE OF NOTARY

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF DEPUTY SHERIFF

21. SIGNATURE OF JAILER

22. SIGNATURE OF DEPUTY JAILER

23. SIGNATURE OF WARDEN

24. SIGNATURE OF DEPUTY WARDEN

25. SIGNATURE OF CHIEF OF POLICE

26. SIGNATURE OF DEPUTY CHIEF OF POLICE

27. SIGNATURE OF SHERIFF

28. SIGNATURE OF DEPUTY SHERIFF

29. SIGNATURE OF JAILER

30. SIGNATURE OF DEPUTY JAILER

31. SIGNATURE OF WARDEN

32. SIGNATURE OF DEPUTY WARDEN

33. SIGNATURE OF CHIEF OF POLICE

34. SIGNATURE OF DEPUTY CHIEF OF POLICE

35. SIGNATURE OF SHERIFF

36. SIGNATURE OF DEPUTY SHERIFF

37. SIGNATURE OF JAILER

38. SIGNATURE OF DEPUTY JAILER

39. SIGNATURE OF WARDEN

40. SIGNATURE OF DEPUTY WARDEN

41. SIGNATURE OF CHIEF OF POLICE

42. SIGNATURE OF DEPUTY CHIEF OF POLICE

43. SIGNATURE OF SHERIFF

44. SIGNATURE OF DEPUTY SHERIFF

45. SIGNATURE OF JAILER

46. SIGNATURE OF DEPUTY JAILER

47. SIGNATURE OF WARDEN

48. SIGNATURE OF DEPUTY WARDEN

49. SIGNATURE OF CHIEF OF POLICE

50. SIGNATURE OF DEPUTY CHIEF OF POLICE

51. SIGNATURE OF SHERIFF

52. SIGNATURE OF DEPUTY SHERIFF

53. SIGNATURE OF JAILER

54. SIGNATURE OF DEPUTY JAILER

55. SIGNATURE OF WARDEN

56. SIGNATURE OF DEPUTY WARDEN

57. SIGNATURE OF CHIEF OF POLICE

58. SIGNATURE OF DEPUTY CHIEF OF POLICE

59. SIGNATURE OF SHERIFF

60. SIGNATURE OF DEPUTY SHERIFF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11525

11531

CERTIFICATE OF DEATH

Reg. Dist. No. 16

Item 13, Film 90 12-22-55 et

1. PLACE OF DEATH: COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Churchton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Churchton</u>	
TOWN <u>Churchton</u>		TOWN <u>Churchton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Broadwater</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Nellie</u> (Middle) <u>JANE</u> (Last) <u>McKenna</u>		4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>3</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>17 July 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>76</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> If under 24 hrs: Hours <u> </u> Min. <u> </u>
13. FATHER'S NAME <u>Daniel Hanner McKenna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>MARY Smith</u>	
16. SOCIAL SECURITY No. <u> </u>		17. INFORMANT <u>Mrs. Thelma Roeder</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 45yo(a) Arteriosclerosis - generalized

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) (c) II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 15 July, 1955, to 3 Dec, 1955, that I last saw the deceasedalive on 30 Nov, 1955, and that death occurred at 8:20 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Dec 6 1955</u>	<u>Woodlawn</u>	<u>Terre Haute Indiana</u>	<u>32 Dec 55</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Dec 3-55</u>	<u>J. B. Kent</u>	<u>Hardisty Funeral Home</u>	<u>Galesville Ind</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 6 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1812553

11532

CERTIFICATE OF DEATH

Item 2, Film G191 1-17-56 et

Reg. Dist. No. 28

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Same</u> <u>Maryland</u>		COUNTY <u>Same</u>	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
X TOWN <u>Millersville</u>		7 months		STREET ADDRESS <u>Same</u> <u>Pines on Severn</u>		X (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sann's Nursing Home.</u>							
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>Mayme</u>		(Middle) <u>Meter</u>		(Month) <u>December</u>		(Day) <u>30th.</u>	
(Type or Print)				(Year) <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		
F.	W.	Widow	2/26/77	78 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Housewife						Luella, Penn. U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
William F. Bush				Birkheiser			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
No						Sann's Nursing Home Records.	

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
422.1 Immediate cause (a) Cardio vascular diseases.					
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO					
(c)					
11. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
		INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5/22/55, 19....., to 12/30/55, 19....., that I last saw the deceased alive on 12/29/55, 19....., and that death occurred at 1 P.M. from the causes and on the date stated above.					
SIGNATURE		(Degree or title)		DATE SIGNED	
<u>Wendell P. Packer</u>		<u>Glen Burnie, Md.</u>		<u>12/30/55</u>	
23. BURIAL, CREMATION, (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>12-31-55</u>		<u>FORT LINCOLN CREMATORY PRINCE GEO. CO MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>Dec 31 1955</u>		<u>K M Joe</u>		<u>John M. Taylor Son Annapoli Md</u>	
<u>Jan-5-56</u>					

82

1583

THE CORPUS

BUREAU V. S.

JAN 9 1932

RECEIVED

K. M. J. C.

100-2-25

MARYLAND STATE DEPARTMENT OF HEALTH

11533

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 25

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>50</u> TOWN <u>Baltimore 25</u> LENGTH OF STAY (In this place) <u>4 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>50</u> OR TOWN <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>398 - Crosswell Ave.</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Isaac</u> (Middle) <u>Anna</u> (Last) <u>Muller</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>12/18/55</u> 19 <u>55</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>10/23/17</u> 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>38</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles McBlaskey</u>		14. MOTHER'S MAIDEN NAME <u>Etta Cornell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>193-05-6250</u>	
17. INFORMANT <u>Mr. Raymond Muller</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

193X Immediate cause(a) Malignancy of Brain5 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

8/18/55 Malignancy of Brain

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Eustace H. Paubert M.D.Superintendent, Inspector (Blau/Bernie) M.D.12/18/55

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF 12-22-55NAME OF CEMETERY OR CREMATORY St. MichaelsLOCATION (City, town, or county) Altoona Pa

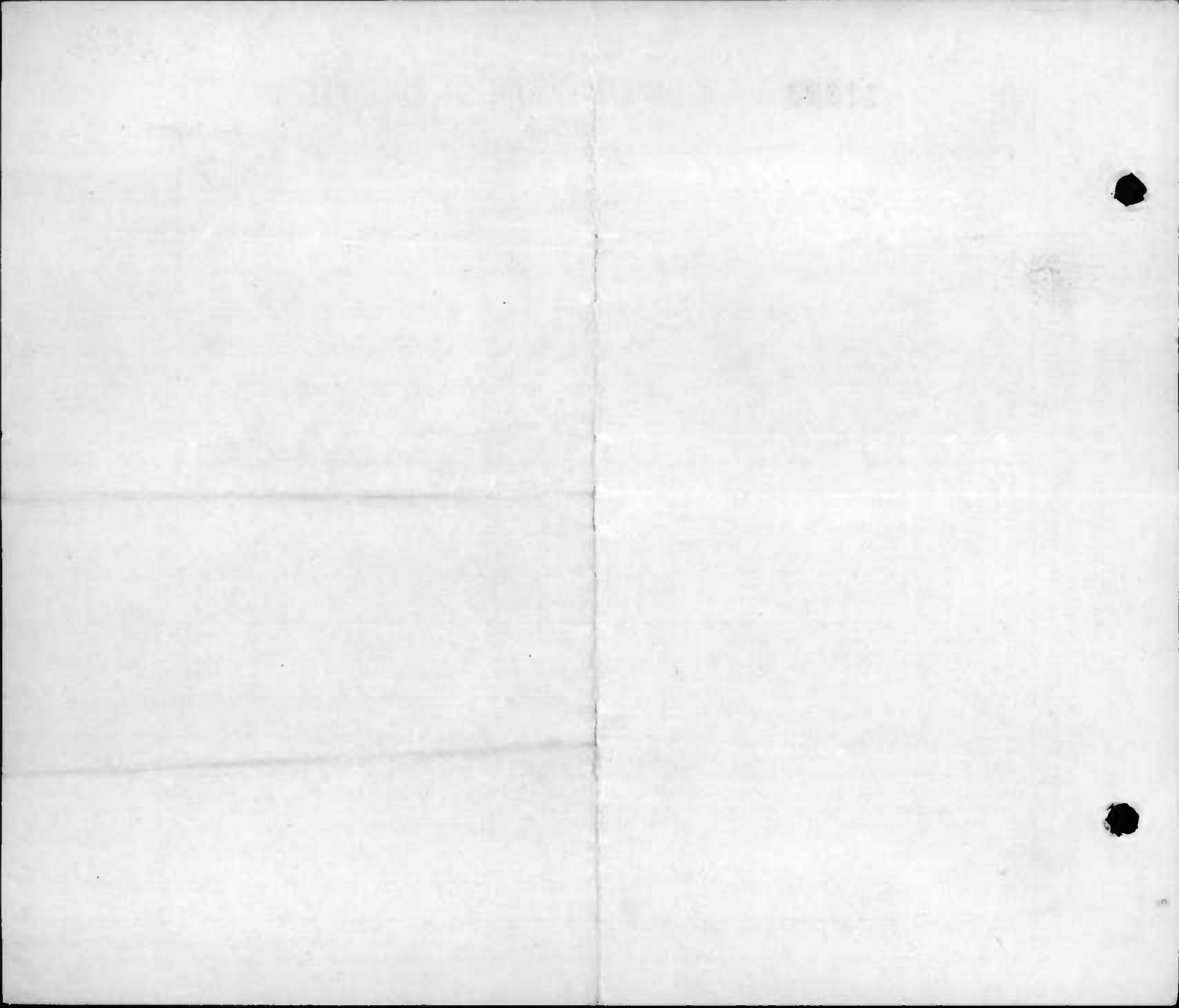
(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE DW Hedrick24. FUNERAL DIRECTOR Wm. E. LaneADDRESS Home

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11493 CERTIFICATE OF DEATH

12551

Reg. Dist. No. 21

1. PLACE OF DEATH <i>Ann Arbor, Michigan</i>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md.</i> COUNTY <i>Anne Arundel</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Annapolis</i>		MARYLAND LENGTH OF STAY (in this place) <i>life</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Ann Arbor, Mich</i>				STREET ADDRESS (If rural give location) <i>202 Duke of Gloucester</i>			
3. NAME OF DECEASED (Type or Print) <i>CLIFFORD OWINGS</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>DEC 31 1955</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W</i>	8. DATE OF BIRTH <i>SEPT. 17, 1872</i>	9. AGE last birthday <i>83</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CARPENTER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>ULYSSES G. OWINGS</i>				14. MOTHER'S MAIDEN NAME <i>FRANCIS NORRIS</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>NO</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT & ADDRESS <i>daughter, Eleanor, Same.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
610X IMMEDIATE CAUSE (A) <i>Uremia</i>						? YRS.	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Prostatic hypertrophy</i>						? YRS.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>2</i>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/29</i> , 19 <i>55</i> , to <i>12/31</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12/31</i> , 19 <i>55</i> , and that death occurred at <i>10:45</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>John H. Hedeman</i>		DATE THEREOF <i>Jan. 3, 1956</i>		NAME OF CEMETERY OR CREMATORY <i>Methodist Cemetery</i>		DATE SIGNED <i>12/31/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Jan. 3, 1956</i>		LOCATION (City, town, or county) <i>Galesville, Maryland</i>		(State) <i>Md.</i>	
24. REC'D BY REGISTRAR DATE <i>Jan 3, 1956</i>		REGISTRAR'S SIGNATURE <i>J. H. Hedeman</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i> ADDRESS <i>Annapolis, Md.</i>			

12

AN 6 1956

RECEIVED

11494 **CERTIFICATE OF DEATH**

Reg. Dist. No. 2-1

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY ANNE ARUNDEL	STATE MARYLAND	COUNTY ANNE	STATE ARUNDEL
CITY OR TOWN ANNAPOLIS	LENGTH OF STAY (in this place) 60 yrs	CITY OR TOWN ANNAPOLIS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 112 OBERRY COURT		STREET ADDRESS 28 SHAW STREET	
3. NAME OF DECEASED (Type or Print) CHARITY (First) SADONIA (Middle) PARKER (Last)		4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 26, 1955	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 4/2/1872
9. AGE last birthday 83 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) DAVIDSONVILLE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? ****			
13. FATHER'S NAME CHARLES JOHNSON		14. MOTHER'S MAIDEN NAME MATILDA STEWART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS DOROTHY WARD-112 OBERRY COURT-ANNAPOLIS			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 199.1 <i>Carcinoma of Abdominal Organs</i>			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-5-55 to 12-26-55, 1955, that I last saw the deceased alive on 12-5-55, 1955, and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
SIGNATURE <i>G. T. Allen</i>		DATE SIGNED 12-28-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		24. REC'D BY REGISTRAR	
DATE THEREOF 12-29-1955		REGISTRAR'S SIGNATURE <i>[Signature]</i>	
NAME OF CEMETERY OR CREMATORY BREWER HILL CEMETERY		LOCATION (City, town, or county) (State) WEST ST. ANNAPOLIS, MARYLAND	
25. FUNERAL DIRECTOR'S SIGNATURE DATE Dec. 28, 1955		ADDRESS ETHEL L. HICKS*45 NORTHWEST ST.*ANNAPOLIS, MD.	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, LBJ Library, Washington, D.C.	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. MEDICAL CERTIFICATION The deceased was found in Room 306 of the LBJ Library, Washington, D.C., on April 4, 1968, at approximately 2:01 PM. He was found with a gunshot wound to the chest. The wound was fatal. The deceased was identified as James Earl Ray, a white male, 35 years of age, 5'10" tall, 170 lbs, brown hair, blue eyes. He was wearing a dark suit, white shirt, and dark tie. He was found with a .38 Smith & Wesson revolver in his right hand. The revolver was loaded with 5 rounds. The deceased was found with a small amount of blood on his shirt. The wound was located in the center of the chest, approximately 4 inches above the waist. The wound was 1 inch in diameter. The deceased was found with a small amount of blood on his shirt. The wound was located in the center of the chest, approximately 4 inches above the waist. The wound was 1 inch in diameter.	
10. SIGNATURE OF DECEASED James Earl Ray		11. SIGNATURE OF NEXT OF KIN Johnnie Lee Ray		12. SIGNATURE OF MEDICAL EXAMINER Dr. J. Edgar Hoover	
13. SIGNATURE OF CORONER Johnnie Lee Ray		14. SIGNATURE OF JURY Johnnie Lee Ray		15. SIGNATURE OF JUDGE Johnnie Lee Ray	

RECEIVED
DEC 30 1965
BUREAU V. S.

NOTICE: This certificate is to be used only for the purpose of reporting the death of a person who has died in Maryland. It is not to be used for the purpose of reporting the death of a person who has died in another state or country. The certificate must be signed by the medical examiner or the coroner who has examined the body. It must be filed with the local health department within 24 hours of the death. The certificate must be kept for a period of 10 years. The certificate must be made available to the public upon request. The certificate must be made available to the public upon request.

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **24 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11528

11534

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		LENGTH OF STAY (in this place) <i>3 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		<i>17</i>	
TOWN <i>Crownsville</i>				TOWN <i>Baltimore</i>		<i>3V01.4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Crownsville State Hosp.</i>				STREET ADDRESS (If rural give location) <i>1600 Yiment Ct.</i>			
3. NAME OF DECEASED (First) <i>Eva</i> (Middle) <i>Perry</i> (Last)				4. DATE OF DEATH (Month) <i>12</i> (Day) <i>1</i> (Year) <i>1955</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>10/4/00</i>	
9. AGE last birthday <i>55</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>- - -</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Anna Williams</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>Unk.</i> (If Yes, give war or dates of service) <i>- - - - -</i>		16. SOCIAL SECURITY NO. <i>- - - - -</i>		17. INFORMANT & ADDRESS <i>Hospital Records</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <i>Cardiovascular Accident</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Generalized Atherosclerosis</i>						<i>undif</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0 - - - -</i>		19b. MAJOR FINDINGS OF OPERATION <i>- - - - -</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>- - - -</i>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7/8</i> , 19 <i>52</i> , to <i>12/1</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12/1</i> , 19 <i>55</i> , and that death occurred at <i>9:30 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Leon W. White</i>				ADDRESS (Street, city, town, state) <i>Crownsville, Md.</i>		DATE SIGNED <i>12/1/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12/5/55</i>		NAME OF CEMETERY OR CREMATORY <i>W. B. Auburn</i>		LOCATION (City, town, or county) (State) <i>Baltimore</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>W. M. Jones</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Charles G. Cooper</i>		ADDRESS <i>512 Carrollton</i>	
DATE <i>DEC 5 1955</i>							

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CORONER

13. SIGNATURE OF BURIAL OFFICER

14. SIGNATURE OF VENDOR

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF CLERK

17. SIGNATURE OF ASSISTANT

18. SIGNATURE OF OFFICIAL

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BUREAU V. S.

DEC 7 1935

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11529

11535

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>-Deale</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Deale</u>				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Deale</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>David Rhinehold Peterson</u>				<u>Dec. 20</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>		<u>6/2/99</u>	<u>56</u>	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Construction superintendent</u>				<u>Wisconsin</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Minnie Peterson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Nora R. Peterson</u> <u>Deale, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Acute myocardial infarction</u>						<u>Immediately</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Occlusion</u>						<u>immediately</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Two previous episodes of same</u>						<u>3 months</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Angina Pectoris</u>						<u>1 Year??</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>29 Nov</u> , 19 <u>55</u> , to <u>Present</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6 Dec</u> , 19 <u>55</u> , and that death occurred at <u>5:00 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. H. Hendricks</u>				ADDRESS (Street, city, town, state) <u>Shady Side, Maryland</u>		DATE SIGNED <u>12-20-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>12/23/55</u>		<u>Washington National Cem.</u>		<u>Suitland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12/23/55</u>		<u>Elsie Test Williams</u>		<u>John L. G. Brown Company</u>		<u>2901-24 St. N.W. Wash. D.C.</u>	

11335 CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Usual residence

7. Date of death

8. Cause of death

9. Place of death

10. Signature of physician

11. Signature of registrar

12. Signature of witness

13. Signature of witness

14. Signature of witness

15. Signature of witness

16. Signature of witness

17. Signature of witness

18. Signature of witness

19. Signature of witness

20. Signature of witness

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BUREAU V. S.

DEC 27 1955

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12552

11536

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>2yrs.3mos.29das.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 25</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS <u>1010 Shellbank Road</u>			
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>Risper, Sr.</u> (Last)				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>23</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>1893</u>	
9. AGE last birthday <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>026X</u> IMMEDIATE CAUSE (A) <u>Cerebrovascular Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Central Nervous System Syphilis</u>				known to us since <u>8/24/53</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Brain Syndrome, Associated with CNS Lues, Meningo-encephalitic type.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u> </u>		21c. WHERE DID INJURY OCCUR? (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u> </u> M. <u> </u> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>8/24</u> , 19 <u>55</u> , to <u>12/23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/22</u> , 19 <u>55</u> , and that death occurred at <u>8:15a</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>12/23/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>				DATE THEREOF <u>JAN 4-56</u>			
24. RECEIVED BY REGISTRAR <u>[Signature]</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>			
DATE <u>Jan. 9, 1956</u>				ADDRESS <u>U of M. MED SCHOOL GREENE ST</u>			
REGISTRAR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Suppl Bldg 1800 E LOMBARD ST</u>			

24001-10-10-10-10-10

RECEIVED
JAN 9 1936
BUREAU V. S.

CERTIFICATE OF DEATH

11336

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

See Civil No.

1. PLACE OF DEATH

2. MANNER OF DEATH

3. CAUSE OF DEATH

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF BIRTH

7. SEX

8. AGE

9. OCCUPATION

10. MARITAL STATUS

11. EDUCATION

12. RELIGION

13. RACE

14. COLOR

15. HEIGHT

16. WEIGHT

17. BUILD

18. COMPLEXION

19. HAIR

20. EYES

21. MOUTH

22. NOSE

23. EARS

24. TEETH

25. SKIN

26. FINGERS

27. TOES

28. OTHER

29. SIGNATURE OF PHYSICIAN

30. SIGNATURE OF REGISTRAR

31. SIGNATURE OF WITNESSES

32. SIGNATURE OF DECEASED

33. SIGNATURE OF NEXT OF KIN

34. SIGNATURE OF CLERGYMAN

35. SIGNATURE OF JUDGE

36. SIGNATURE OF SHERIFF

37. SIGNATURE OF CORONER

38. SIGNATURE OF DISTRICT ATTORNEY

39. SIGNATURE OF COUNTY CLERK

40. SIGNATURE OF TOWNSHIP CLERK

41. SIGNATURE OF VILLAGE CLERK

42. SIGNATURE OF CITY CLERK

43. SIGNATURE OF STATE CLERK

44. SIGNATURE OF NATIONAL CLERK

45. SIGNATURE OF INTERNATIONAL CLERK

46. SIGNATURE OF OTHER CLERK

47. SIGNATURE OF DECEASED

48. SIGNATURE OF NEXT OF KIN

49. SIGNATURE OF CLERGYMAN

50. SIGNATURE OF JUDGE

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75. SIGNATURE OF INTERNATIONAL CLERK

76. SIGNATURE OF OTHER CLERK

77. SIGNATURE OF DECEASED

78. SIGNATURE OF NEXT OF KIN

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80. SIGNATURE OF JUDGE

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86. SIGNATURE OF VILLAGE CLERK

87. SIGNATURE OF CITY CLERK

88. SIGNATURE OF STATE CLERK

89. SIGNATURE OF NATIONAL CLERK

90. SIGNATURE OF INTERNATIONAL CLERK

91. SIGNATURE OF OTHER CLERK

92. SIGNATURE OF DECEASED

93. SIGNATURE OF NEXT OF KIN

94. SIGNATURE OF CLERGYMAN

95. SIGNATURE OF JUDGE

96. SIGNATURE OF SHERIFF

97. SIGNATURE OF CORONER

98. SIGNATURE OF DISTRICT ATTORNEY

99. SIGNATURE OF COUNTY CLERK

100. SIGNATURE OF TOWNSHIP CLERK

101. SIGNATURE OF VILLAGE CLERK

102. SIGNATURE OF CITY CLERK

103. SIGNATURE OF STATE CLERK

104. SIGNATURE OF NATIONAL CLERK

105. SIGNATURE OF INTERNATIONAL CLERK

106. SIGNATURE OF OTHER CLERK

107. SIGNATURE OF DECEASED

108. SIGNATURE OF NEXT OF KIN

109. SIGNATURE OF CLERGYMAN

110. SIGNATURE OF JUDGE

111. SIGNATURE OF SHERIFF

112. SIGNATURE OF CORONER

113. SIGNATURE OF DISTRICT ATTORNEY

114. SIGNATURE OF COUNTY CLERK

115. SIGNATURE OF TOWNSHIP CLERK

116. SIGNATURE OF VILLAGE CLERK

117. SIGNATURE OF CITY CLERK

118. SIGNATURE OF STATE CLERK

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120. SIGNATURE OF INTERNATIONAL CLERK

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130. SIGNATURE OF TOWNSHIP CLERK

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133. SIGNATURE OF STATE CLERK

134. SIGNATURE OF NATIONAL CLERK

135. SIGNATURE OF INTERNATIONAL CLERK

136. SIGNATURE OF OTHER CLERK

137. SIGNATURE OF DECEASED

138. SIGNATURE OF NEXT OF KIN

139. SIGNATURE OF CLERGYMAN

140. SIGNATURE OF JUDGE

141. SIGNATURE OF SHERIFF

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144. SIGNATURE OF COUNTY CLERK

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146. SIGNATURE OF VILLAGE CLERK

147. SIGNATURE OF CITY CLERK

148. SIGNATURE OF STATE CLERK

149. SIGNATURE OF NATIONAL CLERK

150. SIGNATURE OF INTERNATIONAL CLERK

151. SIGNATURE OF OTHER CLERK

152. SIGNATURE OF DECEASED

153. SIGNATURE OF NEXT OF KIN

154. SIGNATURE OF CLERGYMAN

155. SIGNATURE OF JUDGE

156. SIGNATURE OF SHERIFF

157. SIGNATURE OF CORONER

158. SIGNATURE OF DISTRICT ATTORNEY

159. SIGNATURE OF COUNTY CLERK

160. SIGNATURE OF TOWNSHIP CLERK

161. SIGNATURE OF VILLAGE CLERK

162. SIGNATURE OF CITY CLERK

163. SIGNATURE OF STATE CLERK

164. SIGNATURE OF NATIONAL CLERK

165. SIGNATURE OF INTERNATIONAL CLERK

166. SIGNATURE OF OTHER CLERK

167. SIGNATURE OF DECEASED

168. SIGNATURE OF NEXT OF KIN

169. SIGNATURE OF CLERGYMAN

170. SIGNATURE OF JUDGE

171. SIGNATURE OF SHERIFF

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173. SIGNATURE OF DISTRICT ATTORNEY

174. SIGNATURE OF COUNTY CLERK

175. SIGNATURE OF TOWNSHIP CLERK

176. SIGNATURE OF VILLAGE CLERK

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178. SIGNATURE OF STATE CLERK

179. SIGNATURE OF NATIONAL CLERK

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181. SIGNATURE OF OTHER CLERK

182. SIGNATURE OF DECEASED

183. SIGNATURE OF NEXT OF KIN

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193. SIGNATURE OF STATE CLERK

194. SIGNATURE OF NATIONAL CLERK

195. SIGNATURE OF INTERNATIONAL CLERK

196. SIGNATURE OF OTHER CLERK

197. SIGNATURE OF DECEASED

198. SIGNATURE OF NEXT OF KIN

199. SIGNATURE OF CLERGYMAN

200. SIGNATURE OF JUDGE

201. SIGNATURE OF SHERIFF

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204. SIGNATURE OF COUNTY CLERK

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206. SIGNATURE OF VILLAGE CLERK

207. SIGNATURE OF CITY CLERK

208. SIGNATURE OF STATE CLERK

209. SIGNATURE OF NATIONAL CLERK

210. SIGNATURE OF INTERNATIONAL CLERK

211. SIGNATURE OF OTHER CLERK

212. SIGNATURE OF DECEASED

213. SIGNATURE OF NEXT OF KIN

214. SIGNATURE OF CLERGYMAN

215. SIGNATURE OF JUDGE

216. SIGNATURE OF SHERIFF

217. SIGNATURE OF CORONER

218. SIGNATURE OF DISTRICT ATTORNEY

219. SIGNATURE OF COUNTY CLERK

220. SIGNATURE OF TOWNSHIP CLERK

221. SIGNATURE OF VILLAGE CLERK

222. SIGNATURE OF CITY CLERK

223. SIGNATURE OF STATE CLERK

224. SIGNATURE OF NATIONAL CLERK

225. SIGNATURE OF INTERNATIONAL CLERK

226. SIGNATURE OF OTHER CLERK

227. SIGNATURE OF DECEASED

228. SIGNATURE OF NEXT OF KIN

229. SIGNATURE OF CLERGYMAN

230. SIGNATURE OF JUDGE

231. SIGNATURE OF SHERIFF

232. SIGNATURE OF CORONER

233. SIGNATURE OF DISTRICT ATTORNEY

234. SIGNATURE OF COUNTY CLERK

235. SIGNATURE OF TOWNSHIP CLERK

236. SIGNATURE OF VILLAGE CLERK

237. SIGNATURE OF CITY CLERK

238. SIGNATURE OF STATE CLERK

239. SIGNATURE OF NATIONAL CLERK

240. SIGNATURE OF INTERNATIONAL CLERK

241. SIGNATURE OF OTHER CLERK

242. SIGNATURE OF DECEASED

243. SIGNATURE OF NEXT OF KIN

244. SIGNATURE OF CLERGYMAN

245. SIGNATURE OF JUDGE

246. SIGNATURE OF SHERIFF

247. SIGNATURE OF CORONER

248. SIGNATURE OF DISTRICT ATTORNEY

249. SIGNATURE OF

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11530

11495 **CERTIFICATE OF DEATH**Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Pr. Geo's.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>1 wk.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mitchellville</u>		<u>16X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood Convelescent Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Roger Fendall Robinson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 23 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>November 14, 1874</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tobacco Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Gibson Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Tydings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>James K. Robinson</u> <u>Mitchellville, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0 IMMEDIATE CAUSE (A) BRONCHO-PNEUMONIA</u>				<u>12/20/55-30X</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>UREMIA</u>				<u>2WKS.</u>			
(C) <u>RENAL FAILURE</u>				<u>2WKS.</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ARTERIOSCLEROTIC HEART DISEASE</u>				<u>UNKNOWN</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/18</u> , 19 <u>55</u> , to <u>12/23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/23</u> , 19 <u>55</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward L Beck</u>				ADDRESS (Street, City, town, state) <u>4 Laidgate Chd Annapolis</u>		DATE SIGNED <u>12/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Oak Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mitchellville Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 28, 1955</u>		REGISTRAR'S SIGNATURE <u>10 - U. Branch</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>			

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

11531

11537

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 27

Item 23, Film G190 12-27-55 et

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Massachusetts</u> COUNTY <u>Norfolk</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Glen Burnie (rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dedham</u> 58X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Rt. #301</u>		STREET ADDRESS (If rural, give location) <u>504 Sprague Street</u>	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>Francis</u> (Last) <u>Russell</u>	4. DATE OF DEATH (Month) <u>December</u> (Day) <u>13</u> (Year) <u>1955</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>December 9, 1932</u> 23 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>	11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>
13. FATHER'S NAME <u>George Russell</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>Josephine (maiden name unknown)</u>		17. INFORMANT <u>Service record, US Army</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

825X
Immediate cause (a) Hemoperitoneum

Antecedent cause(s) (b) Laceration of right lobe of liver
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

instant

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY (X) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>Rt. 301</u>	(CITY OR TOWN) <u>Glen Burnie</u> (COUNTY) <u>Anne Arundel Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>December 13, 1955</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 1:00 am	HOW DID INJURY OCCUR? <u>Automobile accident</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Unknown</u>	NAME OF CEMETERY OR CREMATORY <u>Unknown</u>	LOCATION (City, town, or county) (State) <u>Boston, Mass.</u>
DATE REC'D BY LOCAL REG. <u>13 Dec 1955</u>	REGISTRAR'S SIGNATURE <u>W.L. Saylor</u>	24. FUNERAL DIRECTOR <u>Unknown</u>	ADDRESS <u>Unknown</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 19 1955

RECEIVED

11538

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) Lake Shore
TOWN Lake ShoreHOSPITAL OR
INSTITUTION OR
STREET ADDRESS Route 5, Box 328

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) Lake Shore
TOWN Lake ShoreSTREET ADDRESS (If rural give location)
Route 5, Box 3283. NAME OF DECEASED:
(Type or Print)(First) (Middle) (Last)
CHARLES C. SANDERS4. DATE OF DEATH: (Month) (Day) (Year)
Dec. 4, 1955

5. SEX:

male6. COLOR OR RACE:
white7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH:

Sept. 11, 18939. AGE last birthday: (If UNDER 1 YEAR) (If UNDER 24 HRS.)
62 yrs. Months Days Hours Min.10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Sheet Metal Worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Christopher Sanders

14. MOTHER'S MAIDEN NAME:

Katherine Sullan15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Ruth L. Sanders, Lake Shore, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

204.1
Immediate cause(a) Acute myelogenous leukemiaInterval Between Onset And Death
6 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Aug. 18, 1955, to Dec. 4, 1955, that I last saw the deceased alive on Dec. 4, 1955, and that death occurred at 4:18 P.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL. (Specify)

burial

DATE THEREOF

12/7/55

NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

LOCATION (City, town, or county)

Anne Arundel Co., Md.

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Wm. Corkin, 1217 St. Paul Street

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8251

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8251

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12599-1

Items 2,11,12,13,14 FilmG192 2-16-56 et

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>West River</u>				TOWN <u>West River</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Shady Oaks Manor</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Lillian M. Schneir</u>				<u>12 28 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Fem</u>	<u>W</u>	<u>M</u>	<u>10/22/98</u>	<u>57</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>St. Louis, Mo.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry Rottman</u>				<u>Katie Beck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				<u>Wm. C. Schneir, West River, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>						<u>Imm.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Old Arteriosclerotic Heart Disease</u>						<u>? ?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pt. under care of H.J.Kurtz, Glendale, Md.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-29-55</u> to <u>12-29-55</u> that I last saw the deceased alive on <u>12-29-55</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. H. Reducks</u> M.D.				ADDRESS (Street, city, town, state) <u>Shady Side, Md.</u>		DATE SIGNED <u>Original 12/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEROF <u>12-29-55</u>		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) <u>St. Louis, Mo.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>W. H. Reducks</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hanlon Funeral Home, Washington, D.C.</u>		ADDRESS	
DATE <u>Feb. 14, 1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Original cert. found and forwarded to us.

BUREAU V. S.

FEB 14 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11533

11496 **CERTIFICATE OF DEATH***Anne Arundel General Hospital*Reg. Dist. No. *21*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>G. G. Co.</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<i>10</i> <i>Annapolis</i>				<i>Annapolis</i>		<i>19</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>163</i> <i>G. G. General Hosp.</i>				STREET ADDRESS (If rural give location) <i>143 King George St.</i>			
3. NAME OF DECEASED (Type or Print) <i>Baby Girl</i> (First) <i>Sears</i> (Middle) (Last)				4. DATE OF DEATH (Month) <i>12</i> (Day) <i>25</i> (Year) <i>1955</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>12-25-55</i>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>James H. Sears</i>				14. MOTHER'S MAIDEN NAME <i>Geraldine E. Jackson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>J. H. Sears #2</i>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<i>762.5</i> IMMEDIATE CAUSE (A) <i>Atelocystic</i>				INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Prematurity</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/25</i> , 19 <i>55</i> , to <i>12/25</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>12/25</i> , 19 <i>55</i> , and that death occurred at <i>11:30</i> A.M. from the causes and on the date stated above.							
SIGNATURE <i>Joseph C. Shukan</i> M.D.				ADDRESS (Street, city, town, state) <i>69 Franklin</i>		DATE SIGNED <i>12/26/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-29-1955</i>		NAME OF CEMETERY OR CREMATORY <i>Private</i>		LOCATION (City, town, or county) (State) <i>Annapolis Neck Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>J. H. Sears</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		ADDRESS <i>1000 ...</i>	

20V5213200

CERTIFICATE OF DEATH

1. DATE WHEN DECEASED

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. MEDICAL HISTORY

10. PRESENT ILLNESS

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. PLACE OF BIRTH

16. DATE OF BIRTH

17. COLOR OF EYES

18. COLOR OF HAIR

19. COLOR OF SKIN

20. COLOR OF TONGUE

21. COLOR OF THROAT

22. COLOR OF CHEST

23. COLOR OF ABDOMEN

24. COLOR OF LIMBS

25. COLOR OF FEET

26. COLOR OF NAILS

27. COLOR OF TEETH

28. COLOR OF GUMS

29. COLOR OF PALATE

30. COLOR OF UTERUS

31. COLOR OF VAGINA

32. COLOR OF CERVIX

33. COLOR OF ENDOMETRIUM

34. COLOR OF OVARY

35. COLOR OF TUBES

36. COLOR OF UTERINE CERVIX

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RECEIVED

BUREAU V. S.

DEC 30 1955

RECEIVED

11539

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

COUNTY Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) Glen Burnie LENGTH OF STAY (in this place)HOSPITAL OR INSTITUTION OR STREET ADDRESS 11 Avenue, Marley Heights

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE SameCOUNTY SameCITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SameSTREET ADDRESS (If rural give location) Same

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print) Margaret L. Slivecky (Slivecky)

4. DATE

(Month)

(Day)

(Year)

OF

DEATH: Dec. 30-1955

19

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

FemaleWhiteJan 22, 191639 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired Housewife10b. KIND OF BUSINESS OR INDUSTRY: at home11. BIRTHPLACE (State or foreign country): Baltimore, Md.12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

George J. Smith

14. MOTHER'S MAIDEN NAME:

Ethel Dashiell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

John Slivecky, husband, above

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
Immediate cause(a) Hypertensive Cardio Vascular diseases

Interval Between Onset And Death

8 months

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1955, to 12/30, 1955, that I last saw the deceasedalive on 12/29/55, 1955, and that death occurred at 7.15 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

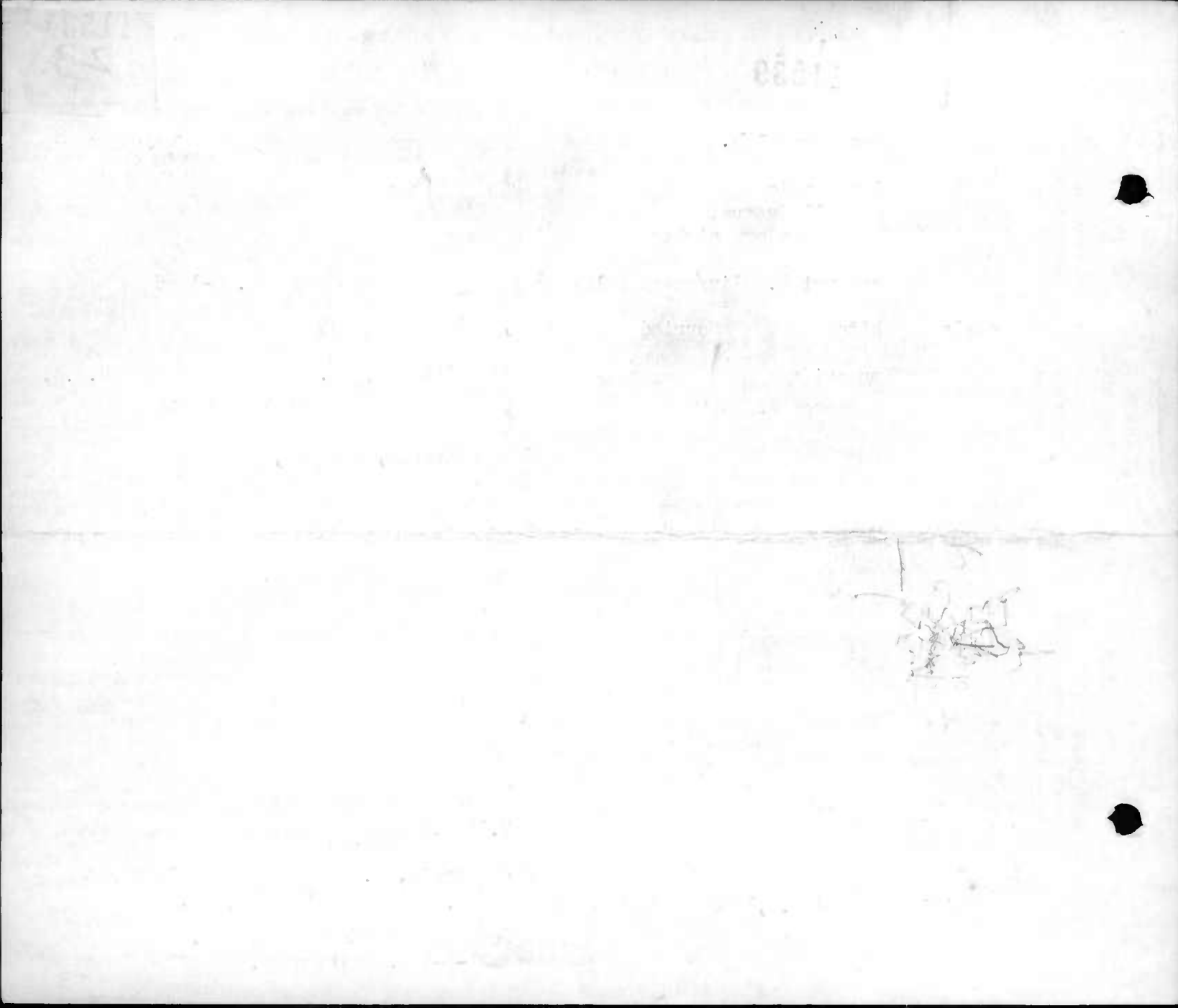
24. FUNERAL DIRECTOR

ADDRESS

Schmunek Funeral Home, Inc.
2601-3-5 E. Madison St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11535

11540

CERTIFICATE OF DEATH

Item 2, Film G191 1-6-56 et

Reg. Dist. No. 28

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Anne Arundel</u> MARYLAND			STATE <u>State Maryland</u> COUNTY <u>A. A.</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		
<u>Millersville</u>		<u>5 1/2 months.</u>	<u>Same// Pasadena</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
<u>Sann's Nursing Home.</u>			<u>Same// Box 12</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH: (Month) (Day) (Year)		
<u>Pearl R. Staples</u>			<u>December 14 19 55</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:		
<u>F.</u>	<u>White</u>		<u>10/27/88</u>		
9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.			10. BIRTHPLACE (State or foreign country):		
<u>67 yrs.</u>			<u>Baltimore, Md.</u>		
11. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.			12. CITIZEN OF WHAT COUNTRY?		
<u>Housewife</u>			<u>U.S.A.</u>		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>Georges Schofield</u>			<u>Ida May Sanner</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		
<u>No</u>			<u>No</u>		
17. INFORMANT & ADDRESS:			18. MEDICAL CERTIFICATION		
<u>Sann's Nursing Home Records.</u>					

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
Immediate cause (a) <u>Cardiovascular diseases</u>		<u>6 months</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Diabetes</u>		<u>?</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/29/55, 19....., to 12/14/55, 19....., that I last saw the deceased alive on 12/9/55 19....., and that death occurred at 3 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title)		ADDRESS		DATE SIGNED	
<u>Glen Burnie, Md.</u>		<u>12/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)	
<u>Burial</u>	<u>12-17-55</u>	<u>Hellerest</u>	<u>Annapolis</u>	<u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS	
<u>Dec 20, 1955</u>	<u>H M J</u>	<u>John M. Saylor</u>		<u>Annapolis Md.</u>	

RECEIVED

DEC 29 1955

BUREAU V. S.

11/11/55

11

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11536

11497

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A.</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>A A</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>10 Annapolis</u>				TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>213 Gloucester St. 19</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>William</u> (Middle) <u>A.</u> (Last) <u>Strohm</u>				(Month) <u>12</u> (Day) <u>15</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>9-10-1886</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>Retired</u>		<u>Postmaster</u>		<u>Annapolis</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Mathew Strohm</u>				<u>Louise Schrader</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes</u> <u>World War I</u>						<u>Nina L. Strohm</u> <u>(2)</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						<u>1 HOUR</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>CORONARY ARTERIOSCLEROSIS</u>						<u>UNKNOWN</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>DIABETES MELLITUS</u>						<u>15 YRS.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>15 DEC.</u> 19 <u>55</u> , to <u>15 DEC.</u> 19 <u>55</u> , that I last saw the deceased alive on <u>15 DEC.</u> 19 <u>55</u> , and that death occurred at <u>6:00</u> M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Edward Beck</u>				<u>41 Southgate Ave</u>		<u>Annapolis</u> <u>12/16/55</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-19-55</u>		<u>St. James</u>		<u>Annapolis Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Dec. 19, 1955</u>		<u>J. J. Daniel</u>		<u>John M. Taylor Sons</u>		<u>Annapolis Md</u>	

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11537

11498

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Items 11, 12 Film 90 12-28-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Annapolis</i>		<i>life</i>		TOWN <i>Cape St. Clair</i>		<i>x</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Anne Arundel Gen'l Hosp.</i>				STREET ADDRESS (If rural give location)			
				<i>1</i>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>FELIX A. VOLNEY</i>				<i>DEC 16 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
<i>M</i>	<i>W</i>	<i>M</i>	<i>11-20-03</i>		<i>52</i> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>RIGGER</i>		<i>COAST GUARD</i>		<i>EUROPE (Czechoslovakia)</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>ANTOINE</i>				<i>JOHANNA</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>no</i>				<i>family - same</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<i>12 DAYS</i>	
<i>420.1 IMMEDIATE CAUSE (A) ACUTE MYOCARDIAL INFARCTION</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						<i>UNKNOWN</i>	
STATING UNDERLYING CAUSE LAST, DUE TO							
<i>DISEASE</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<i>? LIPOMATOSIS</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<i>2</i>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		<input type="checkbox"/> <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <i>12/4</i>, 19<i>55</i>, to <i>12/16</i>, 19<i>55</i>, that I last saw the deceased alive on <i>12/15</i>, 19<i>55</i>, and that death occurred at <i>8:15</i> A.M. from the causes and on the date stated above. <i>12/16/55</i>							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>John L. Hedeman</i>				<i>M.D. 90 Cathedral St. Annapolis, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>12/20/55</i>		<i>12/20/55</i>		<i>Holy Cross</i>		<i>Bk 110</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>DEC 19 1955</i>		<i>Wm. J. French</i>		<i>McLurey Funeral Home</i>			
DATE							

11541

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

COUNTY

Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN LAURELLENGTH OF STAY
(in this place)
16 yrsHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

District Training School

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN LAUREL 47X-3STREET
ADDRESS

(If rural give location)

District Training School

3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

Roland

WARD

4. DATE (Month) (Day) (Year)
OF
DEATH:

Dec. 19

1955

5. SEX:

MALE

6. COLOR OR
RACE:

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

Single

8. DATE OF BIRTH:

July 17, 1927

9. AGE last birthday

28

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):

NONE

10B. KIND OF BUSINESS
OR INDUSTRY:

NONE

11. BIRTHPLACE (State or foreign country):

WASHINGTON, D.C.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME:

ALBERT WARD

14. MOTHER'S MAIDEN NAME:

Dorothy Barker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates
of service)

No

16. SOCIAL SECURITY NO.

-

17. INFORMANT & ADDRESS:

District Training School's files

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

325.0

IMMEDIATE CAUSE

(A)

INANITION

DUE TO

ANTECEDENT CAUSE (S)

(B)

Mental Deficiency - Idiot

DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

Epilepsy

INTERVAL BETWEEN
ONSET AND DEATH

3 months

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
While ☐ Not while ☐
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 25, 1953 to Dec. 19, 1955 that I last saw the deceased alive on Dec. 19, 1955, and that death occurred at 6:45 A.M. from the causes and on the date stated above.

SIGNATURE

Margaret Wong (Mula)

ADDRESS

M.D. District Training School Laurel 12.19.55

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

Dec 20-55

NAME OF CEMETERY OR CREMATORY

Lafayette School

LOCATION (City, town, or county)

Laurel Md

(State)

DATE REC'D BY LOCAL
REGISTRAR

Dec 20-55

REGISTRAR'S SIGNATURE

Lolana Cashep

24. FUNERAL DIRECTOR

Mr John Moore H.T. School

ADDRESS

BUREAU V. S.

JAN 12 1955

RECEIVED

1. INSTRUCTIONS TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11538

11499

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Annapolis</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>A. A. Co</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. A. General Hosp.</u>				STREET ADDRESS (If rural give location) <u>168 O'Berry Court</u>			
3. NAME OF DECEASED (Type or Print) <u>Edgar</u> (First) <u>Washington</u> (Middle) <u></u> (Last)				4. DATE OF DEATH <u>12</u> (Month) <u>28</u> (Day) <u>19</u> (Year) <u>55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>		8. DATE OF BIRTH <u>9-29-1907</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>48</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charles Washington</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Wise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>W. W. II</u>				16. SOCIAL SECURITY NO. <u>21-44-1500</u>		17. INFORMANT & ADDRESS <u>Elizabeth Washington - Annapolis</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
5020 IMMEDIATE CAUSE (A) <u>acute bronchial asthma</u>				<u>2 years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>emphysema of lungs</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-14</u> , 19 <u>55</u> , to <u>12-28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-29</u> , 19 <u>55</u> , and that death occurred at <u>13:45</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Edith Rapplee</u>		M.D. <u>45 Franklin St. Annapolis</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-31-55</u>		NAME OF CEMETERY OR CREMATORY <u>Annapolis National</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Md</u>	
24. REC'D BY REGISTRAR <u>SAV 2 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II</u>		ADDRESS <u>Annapolis, Md</u>	
DATE							

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INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11542 CERTIFICATE OF DEATH

11539

Reg. Dist. No. 24

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Glen Burnie</u>		TOWN <u>Glen Burnie</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Oakwood Road</u>		STREET ADDRESS (If rural give location) <u>Oakwood Road</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ELIZABETH R. WELLS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 15, 19 55</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 11, 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>49</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Bowen</u>		14. MOTHER'S MAIDEN NAME <u>Mary Childs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Oakwood Road</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
171X IMMEDIATE CAUSE (A) <u>generalized carcinomatosis</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of uterus & cervix</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
22. I hereby certify that I attended the deceased from <u>June, 19 50</u> , to <u>Dec 14, 19 55</u> , that I last saw the deceased alive on <u>Dec 14, 19 55</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
SIGNATURE <u>Philip L. Kestner MD</u>		ADDRESS (Street, city, town, state) <u>Baltimore, Md.</u>	
DATE <u>12/19/55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		24. REC'D BY REGISTRAR	
DATE <u>12/19/55</u>		REGISTRAR'S SIGNATURE <u>Louis J. DeAlba</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Kirk, Inc.</u>		ADDRESS <u>1217 St. Paul Street</u>	

CERTIFICATE OF DEATH

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BUREAU V. S.

DEC 19 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

11543

12573

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville		LENGTH OF STAY (In this place) 12yrs, 66 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS None listed		(If rural give location)	
3. NAME OF DECEASED (Type or Print) Eugene Whitmore				4. DATE OF DEATH (Month) (Day) (Year) 12 30 19 55			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 1888?	9. AGE last birthday 67? yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Whitmore				14. MOTHER'S MAIDEN NAME Edda Freese			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT & ADDRESS Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
434.3 IMMEDIATE CAUSE (A) Pulmonary Edema						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) Right heart failure							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CVA							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/21, 19 48, to 12/30, 19 55, that I last saw the deceased alive on 12/30, 19 55, and that death occurred at 10:15 p.m. from the causes and on the date stated above.							
SIGNATURE <i>L. Benedict, M. D.</i>				DATE SIGNED 12/31/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/4/55		NAME OF CEMETERY OR CREMATORY Asbury Hill		LOCATION (City, town, or county) Annapolis, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>William Freese, Anna, Md.</i>		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE 1-6-55							

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INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11540

11500

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glen Burnie (Point Pleasant)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location) <u>Route 2 Box #263 / Shoreland Drive</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Joseph</u> <u>Wielebski</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 28, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>September 22, 1892</u>	9. AGE last birthday yrs. <u>63</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fish Cleaner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown)</u>				14. MOTHER'S MAIDEN NAME <u>Rose (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-16-3557</u>		17. INFORMANT & ADDRESS <u>Mrs. Vera Wielebski Rt. 2 Box 263 Glen Burnie Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic C.V. disease & Hypert.</u>				<u>Yes.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Slight jaundice, Cause unknown</u>				<u>1 w/c.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>12/26</u> , 19 <u>55</u> , to <u>12/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/27</u> , 19 <u>55</u> , and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Maurice Klamans, M.D.</u>				ADDRESS (Street, city, town, state) <u>Annapolis Md</u> DATE SIGNED <u>12/28/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec-31/55</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. REC'D BY REGISTRAR <u>JAN 2 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11541

11501

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>md.</u> COUNTY <u>A.A.</u>		CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Annapolis</u>		LENGTH OF STAY (In this place)		TOWN <u>Annapolis</u>		TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A.A. General Hosp</u>				STREET ADDRESS (If rural give location) <u>65 Solomon Island Rd</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William Frank Williamson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 23 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>7-21-1912</u>	9. AGE last birthday <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) <u>Chuck Driver for Route</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
3. FATHER'S NAME <u>James Henry Williamson</u>				14. MOTHER'S MAIDEN NAME <u>Hurletta Forrester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>770</u>		17. INFORMANT & ADDRESS <u>Marion L. Williamson - Annapolis, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Broncho-Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Uremia with congestive</u>				<u>4 weeks</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Heart failure & Arterio Sclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Dec 23</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 19, 1955, to Dec. 23, 1955, that I last saw the deceased alive on Dec. 23, 1955, and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
SIGNATURE <u>R. L. Richardson</u>		DATE THEREOF <u>Dec 23 1955</u>		ADDRESS (Street, city, town, state) <u>M.D. 110-Clay St Annapolis, Md 12/26/55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>12-26-55 Carpenters Hill</u>		LOCATION (City, town, or county) (State) <u>Round Bay, Md.</u>			
24. REC'D BY REGISTRAR <u>DEC 28 1955</u>		REGISTRAR'S SIGNATURE <u>Hon. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>108 Wash. St. Annapolis, Md.</u>	

CERTIFICATE OF DEATH

Birth Date

2. MARRIAGE HISTORY (MARRIED OR DECEASED)

Place of Birth

Place of Death

1900

1900

1900

1900

1900

1900

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BUREAU V. S.

Dec 19 1900

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DEC 20 1900

RECEIVED

110-50

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1900

1900

1900

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11542

11544

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>4yrs. 8mos. 18das.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Barclay</u>		<u>17X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Leonard</u> (First) <u>Winchester</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>21</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE last birthday <u>27</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harrison Winchester</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>353.2</u> IMMEDIATE CAUSE (A) <u>Status Epilepticus</u>						<u>1 day</u>	
DUE TO ANTECEDENT CAUSE(S) (B) <u>Epilepsy</u>						<u>4/3/51 to 12/21/55</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Mental Deficiency, Idiot</u>							
19a. DATE OF OPERATION <u>2/1</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>4/3/</u> White at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/3/</u> , 19 <u>55</u> , to <u>12/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/20</u> , 19 <u>55</u> , and that death occurred at <u>6:50a.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stanley A. Sargeant</u> M.D. <u>Crownsville, Md.</u>				ADDRESS (Street, city, town, state) <u>Barclay, Md.</u> DATE SIGNED <u>12/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/24/55</u>		NAME OF CEMETERY OR CREMATORY <u>Barclay</u>		LOCATION (City, town, or county) (State) <u>Barclay, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>12-23-55</u>		REGISTRAR'S SIGNATURE <u>K. M. Jace</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulton</u>		ADDRESS <u>Greenboro, Md.</u>	

11545 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Arnold-Near Annapolis</u>		<u>Life</u>		TOWN <u>Arnold-Near Annapolis</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Arnold-Near Annapolis,</u>				STREET ADDRESS (If rural give location) <u>Arnold-Near Annapolis</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LOUISE</u>		(Middle)		(Last) <u>WOODS</u>		(Month) (Day) (Year) <u>12/14/1955</u>	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
Female		Colored		Widowed		October 31, 1880	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
75 yrs.		Housewife		None		Arnold, Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
		Charles Hyntzman		Elizabeth Ackward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, br unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Robert C. Woods- Arnold, Maryland			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				approx 8 hrs			
ANTECEDENT CAUSE(S) DUE TO				by us to our knowledge			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>Generalized arteriosclerosis</u>			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> 19 <u>50</u> , to <u>Dec 14</u> 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 14</u> 19 <u>55</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Faye W. Allen</u>				M.D.		ADDRESS (Street, city, town, state) <u>62 Cathedral St</u>	
DATE <u>Dec 17, 1955</u>				DATE SIGNED <u>12-16-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12/18/1955		Mt. Calvary Cemetery		Arnold, A.A. Co. Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Dec 17, 1955</u>		<u>Ethel L. Hicks</u>		<u>Ethel L. Hicks</u>		<u>43-45 Northwest St. Annapolis Md.</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

11502

CERTIFICATE OF DEATH

Reg. Dist. No. 21

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		<u>18 yrs</u>		TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5 German Street</u>				STREET ADDRESS (If rural give location) <u>1209 West Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JOSEPH</u> <u>ZIFF</u>				<u>DECEMBER 20</u> <u>19</u> <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>April 16, 1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Proprietor</u>		<u>Ladies Apparel Shop</u>		<u>Philadelphia, Pa.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>UNKNOWN</u>				<u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u></u>		<u>Eastern Ave.</u> <u>Mr Rubin A Labovitz</u> <u>Annapolis, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.1</u> IMMEDIATE CAUSE (A) <u>coronary occlusion</u>						<u>1 1/2</u> hr	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic cardiovascular disease</u>						<u>10</u> yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>diabetes mellitus</u>						<u>20</u> yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u></u>		<u></u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u></u>		<u></u>		<u></u>		<u></u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u></u>		<u></u>		<u></u>			
22. I hereby certify that I attended the deceased from <u>12/20/55</u> <u>19</u> <u>to</u> <u>12/20/55</u> <u>19</u> <u>that I last saw the deceased</u> <u>alive on</u> <u>12/20/55</u> <u>19</u> <u>and that death occurred at</u> <u>10:10 P.M.</u> <u>from the causes and on the date stated above.</u>							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>S. Borowski</u>				<u>Amos Garrett Blvd., Annapolis, Md. 12/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 22, 1955</u>		<u>Kneseth Israel Cemetery</u>		<u>Annapolis, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12-22-55</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>HOPPING FUNERAL HOME</u> <u>Annapolis, Md.</u>	

11384

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

REG. NO. 11384

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. COLOR

9. EDUCATION

10. RELIGION

11. SERVICE

12. CAUSE OF DEATH

13. MANNER OF DEATH

14. PLACE OF DEATH

15. TIME OF DEATH

16. SIGNATURE OF DECEASED

17. SIGNATURE OF WITNESSES

18. SIGNATURE OF PHYSICIAN

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF CLERK

23. SIGNATURE OF REGISTRAR

24. SIGNATURE OF NOTARY

25. SIGNATURE OF SHERIFF

26. SIGNATURE OF DEPUTY SHERIFF

27. SIGNATURE OF JAILER

28. SIGNATURE OF WARDEN

29. SIGNATURE OF CHIEF OF POLICE

30. SIGNATURE OF DISTRICT ATTORNEY

31. SIGNATURE OF COUNTY CLERK

32. SIGNATURE OF CITY CLERK

33. SIGNATURE OF TOWN CLERK

34. SIGNATURE OF VILLAGE CLERK

35. SIGNATURE OF BOROUGH CLERK

36. SIGNATURE OF TOWNSHIP CLERK

37. SIGNATURE OF COUNTY COMMISSIONER

38. SIGNATURE OF CITY COMMISSIONER

39. SIGNATURE OF TOWNSHIP COMMISSIONER

40. SIGNATURE OF VILLAGE COMMISSIONER

41. SIGNATURE OF BOROUGH COMMISSIONER

42. SIGNATURE OF TOWNSHIP COMMISSIONER

43. SIGNATURE OF COUNTY COMMISSIONER

44. SIGNATURE OF CITY COMMISSIONER

45. SIGNATURE OF TOWNSHIP COMMISSIONER

46. SIGNATURE OF VILLAGE COMMISSIONER

47. SIGNATURE OF BOROUGH COMMISSIONER

48. SIGNATURE OF TOWNSHIP COMMISSIONER

49. SIGNATURE OF COUNTY COMMISSIONER

50. SIGNATURE OF CITY COMMISSIONER

51. SIGNATURE OF TOWNSHIP COMMISSIONER

52. SIGNATURE OF VILLAGE COMMISSIONER

53. SIGNATURE OF BOROUGH COMMISSIONER

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121. SIGNATURE OF COUNTY COMMISSIONER

122. SIGNATURE OF CITY COMMISSIONER

123. SIGNATURE OF TOWNSHIP COMMISSIONER

124. SIGNATURE OF VILLAGE COMMISSIONER

125. SIGNATURE OF BOROUGH COMMISSIONER

126. SIGNATURE OF TOWNSHIP COMMISSIONER

BUREAU V. S.

DEC 27 1918

RECEIVED